Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund (BCF) planning template. Both parts must be completed as part of your Better Care Fund submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of plan

Local Authority:	**Leicester City Council**
Clinical Commissioning Groups:	**Leicester City Clinical Commissioning Group**
Boundary Differences:	**None**
Date agreed at Health and Wellbeing Board:	**Sign off under delegated authority on behalf of HWB: 18th September 2014** **Full Board will sit on 9th October 2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15 2015/16	 **£14,769,453** **£23,261,000**
Total agreed value of pooled budget: 2014/15 2015/16	 **£14,769,453** **£23,261,000**

b) Authorisation and signoff

Signed on behalf of NHS Leicester City CCG 	
By	Dr Simon Freeman
Position	Managing Director
Date	September 17th 2014
Signed on behalf of Leicester City Council 	
By	Andy Keeling
Position	Chief Operating Officer
Date	September 17th 2014
Signed on behalf of the Leicester City Health and Wellbeing Board 	
By Chair of Health and Wellbeing Board	Cllr Rory Palmer
Position	Deputy City Mayor and Chair of Leicester City Health & Wellbeing Board
Date	September 17th 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Web link or Appendix reference
Better Care Together: LLR five year vision/strategy - June 2014	http://www.bettercareleicester.nhs.uk/information-library/better-care-together-plan-2014/
Leicester City Joint Strategic Needs Assessment (JSNA)	http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jsna-reports/
Joint Health & Wellbeing Strategy (JHWS)	http://www.leicester.gov.uk/your-council-services/health-and-wellbeing/health-and-wellbeing-board/joint-health-and-wellbeing-strategy/
Director of Public Health Annual	http://www.leicester.gov.uk/your-council-

Report	services/health-and-wellbeing/reports/
Leicester City CCG Operational Plan 2014-2016	http://www.leicestercityccg.nhs.uk/about-us/strategies-and-reports/
Leicester City Council Care Act Implementation Plan	 Care Act Programme 29 August 2014.pdf
Programme specific documents	
Detailed scheme descriptions	Annex 1
Provider commentary	Annex 2
Leicester City: contextual analysis	Appendix 1
Leicester City: financial analysis	Appendix 2
Leicester City: Metrics model	Appendix 2a
BCF evidence base	Appendix 3
Leicester City Integrated Care Mobilisation Plan	Appendix 4
Leicester City Joint Integrated Commissioning Board terms of reference 14/15	Appendix 5
BCF Implementation Group terms of reference 14/15	Appendix 6
Leicester City Integrated Care performance dashboard – Sept 2014	Appendix 7
Leicester City Integrated Care risk register – Sept 2014	Appendix 8
Leicester City Integrated Care: risk stratification guide	Appendix 9

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our core vision for Leicester City

Our core vision for this programme, as set out in Leicester's Health and Wellbeing Strategy, '*Closing the Gap'*, remains the same:

Work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life

Our vision for a healthier population goes much further than just ensuring people get the right care from individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care. We will do this through focussing on three priority areas, delivering one integrated model of care:

Priority 1: Prevention, early detection and improvement of health-related quality of life

We will achieve this by:

- Increasing the number of people identified as 'at risk' and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health.
- Delivering 'great' experience and improving the quality of life of patients with long term conditions by expanding our use of available technology, patient education programmes and GP-led care planning, reducing avoidable hospital stays.

Priority 2: Reducing the time spent in hospital avoidably

We will achieve this by:

- Reducing the number of avoidable hospital admissions through the provision of rapid community responses, instead of a 999 response.
- Ensuring every person in the cohort experiences coordinated unplanned and planned care from an integrated team, ranging from health and social care to housing and financial services, which responds in a coordinated way to ensure care is delivered in the community and around the individual.
- Enabling the use of the NHS number as a primary identifier for all patients, linked to high-quality care plans for our frail elderly patients or those with complex health needs.
- Coordinating the flow across our integrated model of care, to ensure that time spent in hospital is minimised.
- Increasing community capacity to look after people in their own homes rather than in a hospital bed.

Priority 3: Enabling independence following hospital care

We will achieve this by:

- Ensuring timely hospital discharge via the provision of in-reach (pull) teams to swiftly repatriate people to community-based services and maintain independence across physical and mental health services.
- Increasing the number of patients able to live independently following a hospital stay.
- Mobilising community-based capacity specifically targeted at mental health service capacity.

At the core of our vision remains a thorough understanding of our population and the health inequalities faced and what we need to do to achieve better outcomes in the short and medium term. A full contextual breakdown of these issues is provided in Appendix 1.

Our vision for 2018/19

Building on our last JSNA in 2012, health and social care organisations across Leicester City (including acute and community providers), embarked upon a transformative approach to integrated care. This was in recognition that our acute-centric model of care required fundamental redesign and on the bases of what our patients and the public had been telling us about their experience of current services.

During 2013/14, a series of pilots were launched based on the vision above, including models of care coordination, integrated crisis response services and enhanced care planning, all designed to reduce the time spent avoidably in hospital through provision of community services. We have used these pilots as the key building blocks upon which our BCF is constructed and we will use the BCF to accelerate our progression towards our end vision, delivered over the next five years:

As at 2012/13:

Fragmented pathways across health and social care, not mapped to general practice

Unsustainable demand on all services, creating a significant financial gap by 2018/19

Significant variation in outcomes from care as a result of health inequalities

Sub-optimal provider performance as a result of demand on services and processes between sectors

Insufficiant workforce, both in terms of capacity and capability to deliver new models of care

Sub-optimal use of assets & resources across LLR

By the end of 2015/16:

Preventative services co-located into one **Lifestyle Hub**, with a single referal process

Joint health and social care teams, with streamlined referal pathways, matched to GP localities, providing a two hour response in crisis

Increased p**lanned care** community capacity, including in g**eneral practice capacity** to provide care in the community, focussing on acute demand reduction

Co-located access teams, making the best use of assets across the health and social care system, with **joined up IT systems**

By the end of 2018/19:

Preventative models of care embedded into every pathway of care, with a city-wide **Lifestyle Hub**

A new **model of primary care** launched across the city, ensuring timely access, care planning and management, with **one simple integrated pathway into community support**

Neighbourhood health and social care teams with single referral pathways & assessment processes, working in specific GP localities, **with one IT system**

A new model of integrated care, fully utilising **joint teams across neighbourhood areas** to deliver seamless care

Although organisations across the city had been moving towards a more integrated model of care, a transformation of this scale and ambition would not have been possible without the advent of the Better Care Fund process. The level of integration suggested over the first two years of this five year vision would perhaps have not been delivered at

the scale and pace proposed in this plan. Certainly, the level of system-wide focus and engagement required to construct our plan has only accelerated both our ambition and motivation to make our system better for those it services.

Delivery of the Leicester City vision for integrated care

Aims of our system

Based on our vision and the context in which we are working, the Leicester City Better Care Fund aims to:

- Design and commission services centred on our patients, public and carers, with our patients, public and carers
- Empower our population to be both better informed and better manage their own health and wellbeing using a range of traditional and digital media and technology
- Develop a new model of primary care that provides a more proactive, holistic and responsive community service across physical and mental health, increasing capacity where required
- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing
- Ensure that people are kept independent for as long as possible following hospital care

Delivery of these aims will be through our model for integrated care, which is based on a menu of services for different scenarios in a patient's life, supporting prevention through to end-of-life care. In enacting our BCF plans we will maintain our responsibilities for patient safety and quality.

Target population

Since 2012 Leicester City CCG has supported practices in using the Adjusted Clinical Groups (ACG) risk predictive software (licenced from Johns Hopkins University in the USA) to risk stratify their registered population and identify those at highest risk of admission to hospital in the next year. We have invested in this to enable our practices

to proactively identify patients at high risk of admission and apply a Multi-Disciplinary Team approach to their care.

We have used ACG-derived risk stratification, along with other methods of grouping the population outlined in the BCF technical toolkit such as grouping by age and condition, to identify our target BCF cohort, i.e. those patients who are at most risk of deterioration or at risk of a significant care event. Through the provision of high quality, integrated health and social care services, our core aim is to reduce the probability of an emergency admission in this cohort.

Our analysis has concluded that the highest 20% at-risk patients account for over 60% of the total cost of emergency admissions for the CCG. Our analysis has also shown us that those patients, regardless of age, who have three or more co-morbidities, have more Non-elective (NEL) spells at a far greater cost than the rest of the population.

Figure 1: Population segmentation by age, multi-morbidity (May 2014)

Combining these sources of intelligence, leads us to a target the following segments of the population:

- those aged 60 and over;
- those who are 18-59 with three or more health conditions (from a locally defined list of conditions that should be treated out of hospital);
- those with dementia.

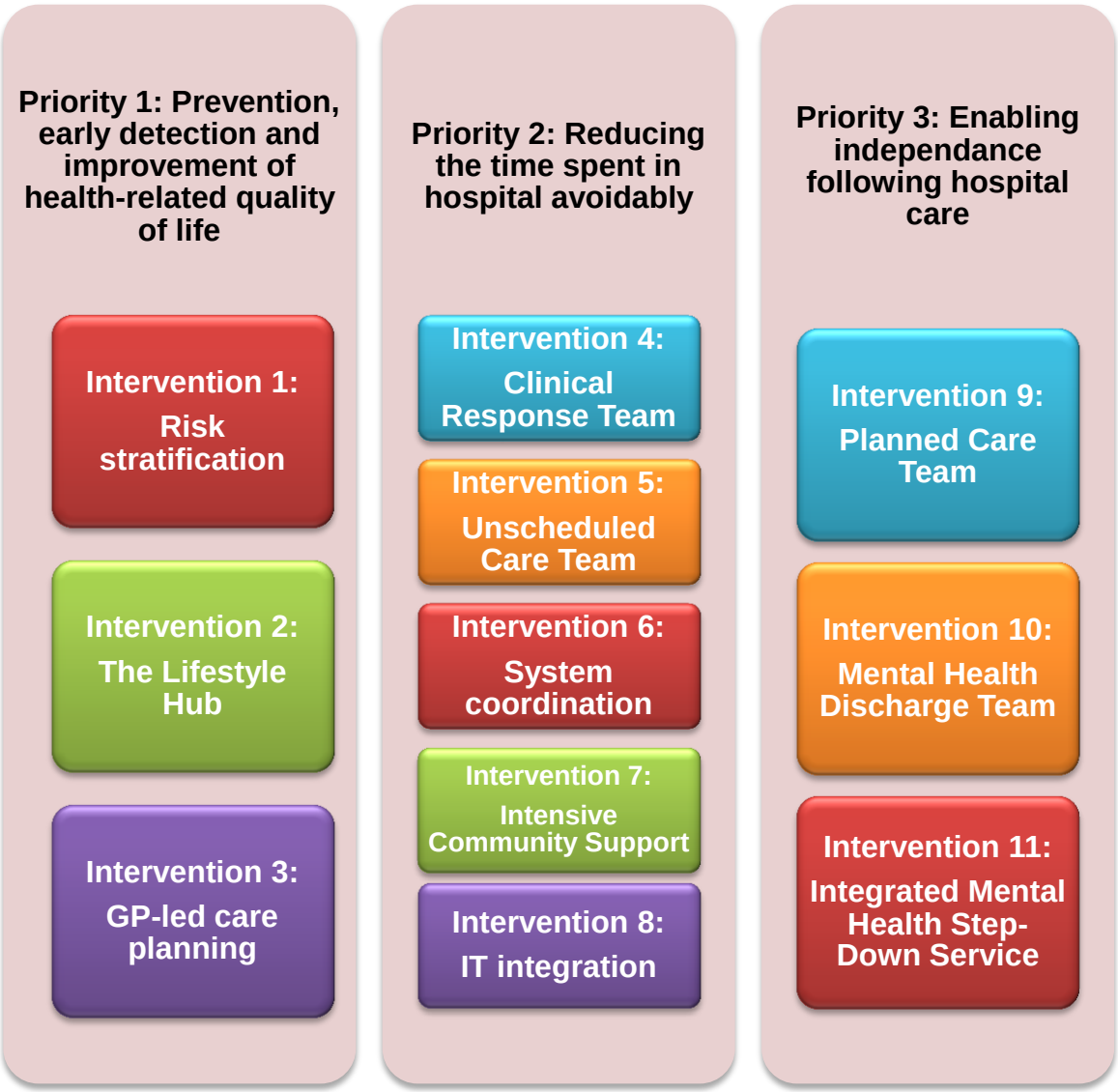
This gives us a target BCF cohort of approximately 93,605 patients; this is small enough to be manageable by the BCF interventions but a sufficient number through which large scale change can be evidenced.

Further detailed analysis for this cohort is outlined in Section 3 of this plan.

The Leicester City integrated care model

Our priority areas for the Better Care Fund have been chosen primarily to ensure pathways of care are changed across our whole system for the benefit of our target BCF population, effectively responding to the public health needs identified throughout this plan and the broader demographic and socio-economic context across the city.

To deliver this change we have been focussing on the three priority areas outlined below since 2013/14. We are using the BCF to either accelerate specific, evidence-based interventions which have been piloted in 2013/14 or implement new interventions based on our learning.



What each of these will deliver and how they will impact on patient outcomes is detailed below.

Priority 1: Prevention, early detection & improvement of health related quality of life				
Public health need	**Intervention**	**Impact on system**		**Impact on patients**
		Two Year	**Five Year**	
Poor health outcomes are associated with social and biological determinants, such as age, sex, deprivation, income and environment. We know that: 41% of the population live in areas classified as the fifth most deprived 50% of the population is from a BME background, with large segments of the population at greater risk of specific diseases such as CVD. Premature deaths are mainly as a result of CVD, cancer or respiratory disease Life expectancy is significantly lower than England average Only 12% of the population is 65 years+	**Risk stratification** Implementation of the Adjusted Clinical Group RS tool, allowing GPs and health and social care commissioners to stratify their population in terms of probability of emergency admission	Ability to identify patients at varying levels of predicted risk in order to ensure a more personalised approach to prevention and early intervention and LTC management	Use of system to: 1. Allocate resource according to case mix of population 2. Population segmentation and profiling to better understand opportunities for further population health improvement 3. Transparent and open performance management of a range of providers, reducing health inequalities and increasing value for money	63 year old male patient with diagnoses of type 2 diabetes, elevated serum cholesterol/marginally raised blood pressure / stable angina and recent admission to emergency department for management of diabetic ketoacidosis. ACG prediction of risk of unplanned admission of 32.7%, and relative risk of 9.37 (= likely to use 9.37 times the CCG average amount of health care resources) 7 OPD appointments and 1 emergency admission in the last 12 months. Identified by the ACG system as part of the GP's top 2.1-10% highest risk cohort. Letter sent to patient explaining he had been identified for extra support – including having a GP appointment to discuss health needs and plan care. Following GP appointment the patient: • Has had a pneumococcal vaccine and been booked for his seasonal flu vaccine • Has agreed to attend the local DESMOND course (type 2 diabetes education) • Has been prescribed medication to address erectile dysfunction associated with his diabetes • Has a written care plan focusing on weight management and a structured approach to monitoring blood sugars and a tiered self-management response to abnormal glucose readings – both in and out of hours Following referral to the Life style Hub the patient enrolled in the Fit and Active Families programme with the aim of losing a stone in 3 months under the supervision of a health trainer. Now plays "Walking Football" twice a week and has been on a guided supermarket visit
	Lifestyle Hub A telephone-based referral hub will manage the referral of adults to relevant lifestyle services, such as smoking cessation, nutrition classes, exercise referral etc	GPs city-wide will be able to refer into the service, with additional classes made available as demand increases	One streamlined lifestyle centre servicing the city, with GPs, health professionals and citizens able to access the lifestyle hub, with prevention embedded into all services.	
	GP care planning Using risk stratification, identification and systematic care planning for the 2.1-10% highest risk patients. Patients will get a 30 min consultation with practices for care planning purposes, covering lifestyle, health needs and the support needed from health and social care to prevent episodes of crisis potentially leading to acute activity	16, 921 care plans completed for high risk patients, with identified health and social care support to keep patients safely in their own homes and reduce the reliance on acute services	Continuous care planning cycle across the city population, ensuring that patients have access to high quality community services, preventing acute activity and improving patient experience of care	

The target population for this priority

This priority area targets those in the 2.1-10% and 10%+ populations as these are the segments which are most amenable to intervention.

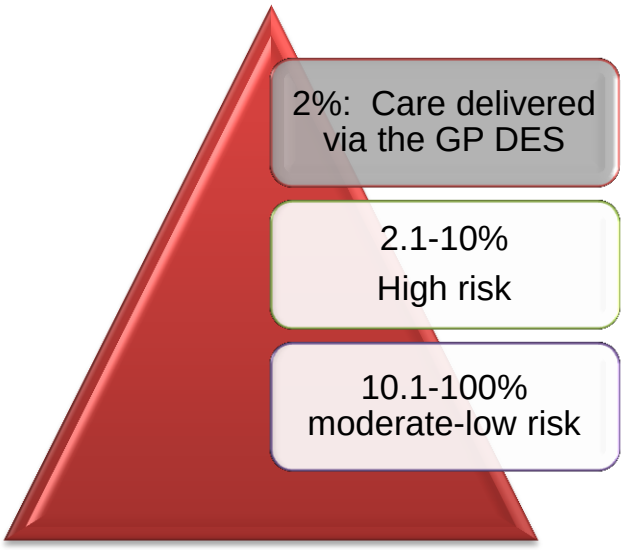


Figure 2: The target population for the Leicester City BCF Priority 1

People who can manage their condition alone need effective and timely professional support in order to prevent progression to more severe stages of the disease and to remain independent for as long as possible. This group also needs effective lifestyle intervention to reduce their risk of other LTCs.

Less than a third of patients with LTCs will require more involvement of healthcare services in managing their disease. This care may be given by increasingly specialist multidisciplinary teams providing high-quality, evidence-based care.

The interventions targeted to this priority area

Intervention 1: Risk stratification

As detailed throughout this plan, the risk stratification tool has enabled commissioning of targeted health and social care and is a vital resource for the future. Using the BCF investment, we plan to accelerate the use and function of our ACG model (licenced from Johns Hopkins) to enable functionality in the following areas:

- research
- public health
- case management
- resource allocation
- performance management.

The LLR Information Management and Technology programme board, which is part of the governance system for the LLR five year plan, is taking the lead with respect to the developments needed locally to improve the data sharing, information management and

technological platform for the local health and care system. The status of the current information sharing agreements has already been identified as a key issue to resolve.

An action plan is being developed to address this and will be designed to enable the approach recommended in the BCF guidance to become a routine part of system-wide analysis for the health and care economy in the medium term.

Practice-level use of this data

We are working with Greater East Midlands Clinical Support Unit and practices to complete this work and currently all 62 practices across Leicester City are actively using the risk stratification tool to manage three key population segments of interest:

1. the 2% highest risk patients in the city;
2. the segment of the population comprising the 2.1-10% highest risk patients in the population;
3. a frail and multi-morbid segment older segment of the population at high risk of adverse effects of polypharmacy.

For the BCF cohort we have set individual practice targets based on key evidence-based interventions for long term conditions and on ensuring that patients are given ready access to the wide range of health and social care services and pathways which can support patients, carers and practices in dealing with the challenges of living with LTCs.

The interventions for these cohorts include:

- more eligible patients and carers having the seasonal flu and pneumococcal vaccines;
- all patients being offered a care plan which will be shared with other relevant providers using the special patient note system;
- frail over 75 patients being referred to Care Navigators for a proactive holistic assessment of health and care needs;
- more older people having cognitive function screening to increase the numbers with a confirmed diagnosis of dementia and therefore access to a whole suite of support and monitoring options;
- access to environmental assessments and medication reviews for patients who have had a previous fall (as per NICE guidelines);
- medicines reviews for patients on multiple medicines.

In addition; we have worked with our medicines management team to produce a guide for GPs on using the filters on the risk stratification system to identify a frail older population with multi morbidity for invitation to attend the practice for a GP consultation based on the STOPP/START tool – a medicines review tool for elderly patients. The aim here is to systematically reduce iatrogenic harm from polypharmacy. See Appendix 9 for a copy of the guide.

Guides have been produced for practices to identify and then manage their DES and BCF cohorts; these are attached to this submission as Appendix 9. The screen shot below illustrates the wealth of information derived from the risk stratification system (patient identities have been removed). The arrows seen towards the right of the screen indicate whether the patient's risk has been going up, down or staying the same compared to 6 months ago.

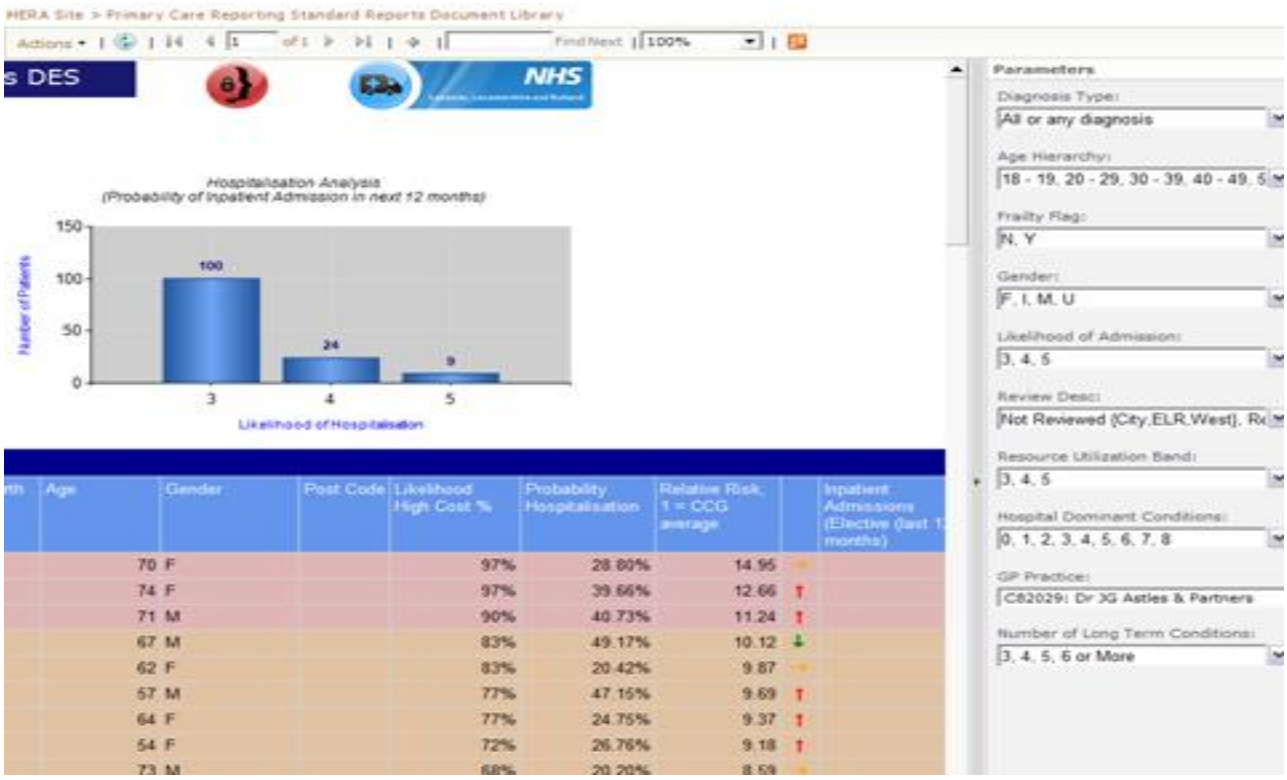


Figure 3: Example of Risk Stratified practice population

Once identified, each patient is reviewed at an MDT if they have highly complex health and social care issues – or by the GP or practice nurse if their medical issues are more focused on a single dominant LTC. Many patients are also referred on to adult social care (ASC) and or community health services for further assessment. This results in patients accessing a variety of interventions across health and social care, all coordinated through the patient's GP. The MDT guide in use across the city is attached as Appendix 9.

System level use of this data

The planned and unscheduled care teams, described later in this section, form a core part of the Leicester City Integrated Care pathway. To ensure all teams from general practice through to community teams and indeed clinicians in ED have appropriate access to relevant patient care plans etc, we have strived for a single system to be used across the city using the BCF as an accelerator. 97% of the city general practices use SystmOne as do all community teams. SystmOne Viewer has been installed in both ED and on EMAS hardware, to ensure that the patient's care plan is followed where appropriate.

In September 2014, 'Status Alerts' within SystmOne were introduced for those patients on the Admission Avoidance and Better Care Fund registers. The aim of these is to help identify patients at risk of emergency admission etc. so that the appropriate actions can be taken and they alert the user to any outstanding actions (e.g. patient does not yet have care plan in place). The relevant template can be accessed by clicking on the icon and the personalised care plan can thus be easily accessed and completed.

There is also now a Status Alert to identify those patients marked as at risk of dementia or who are in the Dementia DES at risk group but who have not been offered or have declined either initial dementia questioning or a dementia assessment. Patients with this icon should be offered initial dementia questioning and those patients with a memory concern should be offered an assessment for dementia. The LCCCG dementia template can also be accessed by clicking on the icon in the SystmOne demographic box.

These alerts will not only aid practices to identify at-risk patients but will enable the Leicester City Planned and Unscheduled teams to access care plans ahead of winter to enable them to support the integrated health care team to keep people out of hospital when it is safe to do so.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities	The system will allow a change in the way in which we commission health and social care. Once we are able to segment the population, this will allow us to better understand opportunities for further population health improvement and could potentially enable allocation of resource according to case mix of population
Reduction in barriers to access	This will also allow transparent and open performance management of a range of providers, reducing health inequalities and increasing value for money

Intervention 2: The Lifestyle Hub

The Lifestyle Referral Hub is an integrated approach to supporting people to attain and maintain good health, based on a model of best practice in Nottingham City.

The Lifestyle Hub will:

- Provide a simple, effective and reliable “one stop” referral service for GPs and other health care professionals;
- Look beyond single issues and undertake a holistic assessment of clients’ needs, state of readiness to change, and identify any barriers to change that may need addressing before the client can engage with services e.g. debt, housing problems;
- Support clients to access appropriate lifestyle services such as Food & Activity Buddies, DHAL, Active Lifestyle, walking groups, cycle training, Heart Smart group and smoking cessation, and build emotional resilience and self-confidence;

- Motivate clients to make and sustain behavioural changes to reduce their risk factors;
- Work with individual GP practices to maximise appropriate referrals;
- Monitor the progress of clients and ensure appropriate feedback is provided to GPs.

A telephone based referral hub will manage the referral of adults to relevant lifestyle services. Individuals in need of support to address lifestyle risk factors (e.g. smoking, poor diet, inactivity, obesity etc) will be referred to the Lifestyle Hub by GPs and other health professionals in primary care. In the longer term it is proposed to expand the hub to allow clients to self-refer.

The provider will initially contact the referred client by phone. Trained staff will then introduce the service, assess the needs of the client (including lifestyle risk factors and willingness to change), provide client-centred motivational support, identify lifestyle services appropriate to the client's needs and preferences and obtain and document the consent of the client to transfer details to other service providers. Clients will then be followed up after 4-6 weeks to assess whether further support is required. Clients will also be followed up 6 months after the final contact to assess progress and maintenance of behaviour change, provide additional motivational support as required and refer to other relevant services as appropriate. Clients may also be signposted to unstructured activities such as volunteering opportunities, parks and active transport initiatives depending on their needs.

If it is apparent during the initial contact that the client requires additional support and is eligible for the full health trainer service (i.e. lives in an area of high deprivation), one to one support with a health trainer will be offered. This gives clients the opportunity to work with a health trainer for a maximum of 12 months to develop a Personal Health Plan (PHP) and work towards achieving sustainable behaviour change.

The Lifestyle Hub has been approved by the Health and Wellbeing Board, as well as the CCG Governing Body as an integral part of the prevention offer across the City, with the aim of offering this service to only targeted areas of the population. With the introduction of the BCF, this is being accelerated to all parts of the City by 2015/16.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities	Lifestyle risk factors are socially patterned and more prevalent in deprived communities. Addressing lifestyle risk factors will benefit deprived communities proportionately more. 80% of health trainers to be recruited from the most economically deprived areas in Leicester
Reduction in barriers to access	50% of new client registrations will be from BME communities

	50% of new client registrations will be men (men are currently under represented in clients accessing health improvement service)
Achievement of Personal Health Plans: • % weight loss for clients with weight loss as a goal • Increased fruit and vegetable consumption for clients with diet improvement as a goal. Increased sessions of moderate/vigorous intensity activity for clients with physical activity as a goal • Proportion of clients achieving four week quit where smoking cessation is a goal • Proportion of clients not exceeding guidelines for safe drinking levels	60% of users will reach partial achievement, 45% full achievement
	Clients will aim to lose an average of at least 3% total body weight
	Clients will aim to intake an average of at least 1.5 portions/day
	Clients will access at least 2 sessions/week
	50% of clients will quit smoking
	70% of clients will reduce their alcohol intake to safe levels

Figure 4: Key impact measures of this intervention

Intervention 3: GP practice support

To support the BCF identified cohort , practices across the city will aim to address their top 0 – 2% high risk patients via the Unplanned Admission DES, allowing them to maximise the BCF funding on the 2.1 -10% high risk population.

This proposal will ensure the identification of patients who are in need of better care and provide experienced clinical time to:

- Undertake routine assessments of patients with long term conditions in their home. This helps people with such conditions to better manage their own health and avoid unnecessary visits to hospital;

- Increase population-based interventions e.g. access to vaccinations, reducing social isolation, increasing access to third-sector and Local Authority services;

- Improve, for selected high-risk individuals, chronic disease management, medicines related safety and concordance;

- Improve self-care and self-management skills; reiterating local ‘Choose Better’ campaign messages where appropriate

- Promote use of personal health budgets;

- Provide both proactive and reactive care;

- Assess carers' health needs; enhancing the resilience of the carer population;

- Prescribe and administer medications within the remit of local Patient Group Directive (PGD), where appropriate, and undertake medication reviews across the cohort;

- Take a holistic approach to patient care, bringing together their medical, social and psychological needs – both for patients and carer;

- Refer patients to alternative health and/or social services through appropriate signposting and guidelines, linking with the wider BCF services and supporting patients in their own homes;

- Ensure high quality, detailed care plans are in place and up to date/reviewed.

7 of 11 published reviews which were analysed found a positive impact of assessing care plans, (McKinsey, 2013). Other studies showcased in the North West London Toolkit (2014) have shown a reduction in hospitalisations by ~23%. By concentrating the work on this cohort of patients, each locality will be maximising the impact on the workload in avoiding unnecessary emergency admissions whilst providing patients with appropriate support and advice to minimise ill health.

What will this mean for our citizens?

Health &/or wellbeing need:	**Impact of this intervention on patient outcomes:**
Reduction in health inequalities	Increase in number of seasonal flu/pneumococcal vaccinations undertaken Increase in recording of Residential Institute (RI) codes on patient records Increase in the number of people on the dementia registers Increase in the number of MURs undertaken (Medicine Usage Reviews)
Reduction in barriers to access Reduction in premature mortality	Evidence of increased referrals to the following self-care services: • DESMOND/DAFNE for diabetic patients • Pulmonary rehabilitation • Heart Failure Nurse Specialist • SPRINT for COPD patients • STOP for smokers

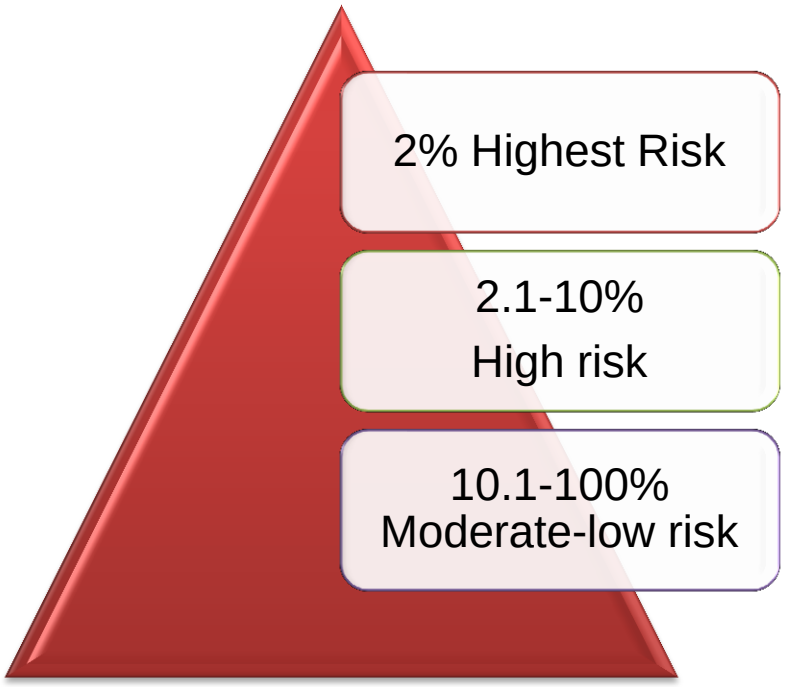
	• Lifestyle hub Additional hours/appointments for planned services Additional hours/appointments
Support independence for people with LTC/older people/people with dementia	Increased number of care plans in place for the 2.1-10% high risk cohort Care Navigator for 75+ patients Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions • A&E reductions in activity at UHL, both in expenditure and activity; • Reductions in emergency admissions from care homes.

Figure 5: Key impact measures of this intervention

Priority 2: Reducing the time spent in hospital avoidably				
Public health need	Intervention	Impact on system		Impact on patients
		2 Year	5 Year	
We know that: Leicester City patients over 60 yrs of age have a 69% chance of being admitted to a bed, regardless of why they attend ED 20% of admissions are unnecessary and should be treated in the community The risk of a diabetes related admission is twice as high in the disadvantaged areas of the city Leicester City historically is acute centric, with poor use of community services 1 in 5 999 conveyances could be avoided if care plans were shared	The Clinical Response Team A GP-led team of clinicians who respond to non-life threatening 999 calls which do not need conveyance to hospital	Reduction in bed base	Reduction in bed base	80 year old female presses her Leicester Care pendant alarm and tells the call handler that she is sitting on her sofa and cannot get up. Call handler calls 999 to request an ambulance. Call is categorised as G3 (non life-threatening) and is passed to the Clinical Assessment team at EMAS who alert the CRT GP. CRT GP diagnoses a bladder infection and dehydration. GP phones Single Point of Access to mobilise Unscheduled Health and Social Care Team. Nurse and care management officer arrive within 40 minutes. Three times daily calls commenced for personal care, assistance with eating and drinking, administration of antibiotics, monitoring of vital signs. Further assessment of home reveals need for grab rail in bathroom and stair case, chair riser, threshold levelling and half step from kitchen to garden. Following discussion with system coordinator, patient admitted to Intensive Community Support Service as she requires overnight nursing monitoring and personal care at home. Remains for two weeks with ICS. Infection resolved after 8 days but patient very deconditioned from prolonged immobility and poor nutrition. Enters 6 week programme of reablement with therapy goals of re-establishing independence with regard to dressing, washing and walking to post office/hairdresser. Outside light installed in garden. Kitchen fitted with range of aids and appliances to improve safety and promote independence. On exit from reablement patient is fully independent. She attends a lunch club each Friday.
	The Unscheduled Care Team A joint health and social care team, designed to keep patients safely at home and avoid an emergency admission. 2 hour response for up to 72 hours of care	Reduction in bed base	Reduction in bed base	
	The system coordinator A post which will ensure flow across the system; breaking down barriers and cultural historical issues between and within organisations	Reduction in bed base	Reduction in bed base	
	Intensive Community Support Service 30 virtual beds to enable discharge home for patients who have had an acute episode of care	Reduction in bed base	Reduction in bed base	
	IT integration New systems to enable joint record sharing and the use of the NHS number as the primary identifier across teams	Better communication between agencies will result in efficient services and better patient experience	One system, linked across every agency in LLR will lead to reduced numbers of patients accessing acute care	

The target population for this priority area

The BCF cohort in its entirety will be targeted by the interventions listed in this priority area.



The interventions targeted to this priority area

Intervention 4: The Clinical Response Team

The Better Care Fund will be used to commission a range of services designed to treat suitable patients who are in crisis in the community, rather than at the acute site.

This intervention will involve the mobilisation of a virtual team of up to six local GPs/ECPs who will respond to 999 calls deemed clinically appropriate, seven days a week between 8am and 8pm. The teams will respond to a pre-agreed referral criteria, either as a first response for lower category calls or as a secondary response from paramedics on scene to provide appropriate safe and timely clinical treatment to maximise opportunities to avoid unnecessary ambulance dispatches, visits to A&E or short stay unplanned medical admissions when they could be looked after at home by a GP.

The clinicians will assess, treat and stabilise the patient and, if appropriate, prevent the requirement for conveyance to the ED at the acute site, preventing the ED attendance and preventing a potential admission into an acute bed. Referrals to community services will be utilised wherever possible to ensure an appropriate immediate intervention and a programme of ongoing care developed to try and prevent the need for unnecessary contact with emergency services in the future. In addition, it will help to educate the public around the range of community services available within the city.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities Reduction in premature mortality	More people will be referred to their own GP practice for further care planning and assessment of needs
Support independence for people with LTC/older people/people with dementia	More people will be treated in their own homes, with no acute intervention More people will be directly referred to the Unscheduled Care Team/Planned Care Teams Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions; • A&E reductions in activity at UHL, both in expenditure and activity; • Reductions in emergency admissions from care homes.

Figure 6: Key impact measures of this intervention

Intervention 5: The Unscheduled Care Team

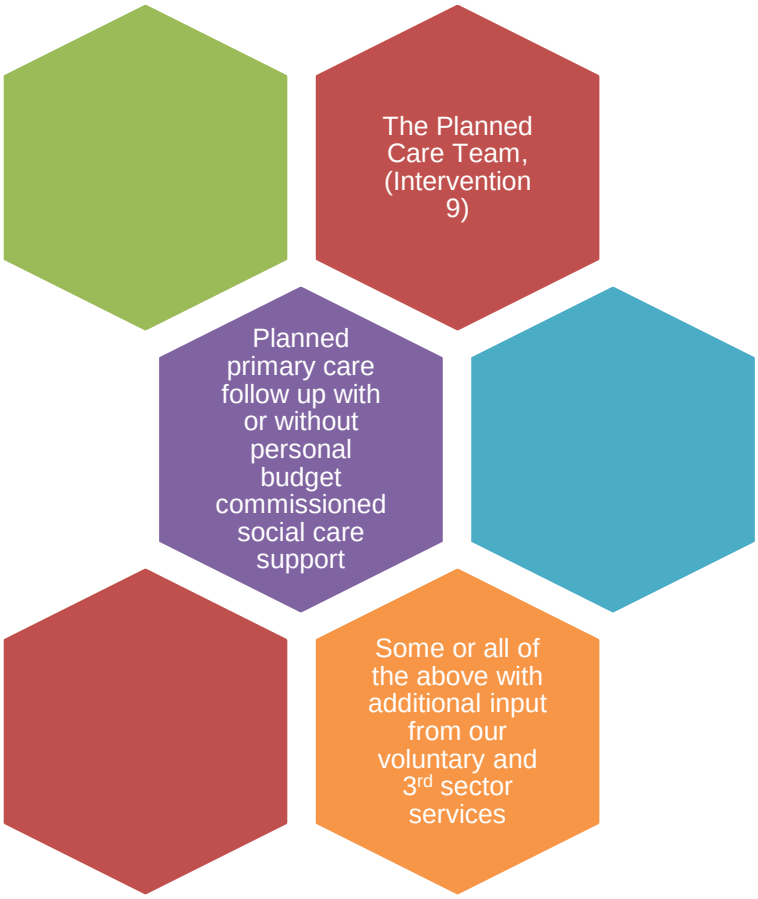
This intervention will bring together health and social teams piloted in 2013/14 into one integrated Unscheduled Care Team, which is aligned to a geographic area and set of GP practices. The team will provide a 2 hour response 24/7 through one Single Point of Access.

The team will provide:

- a Single Point of Access (SPA) for integrated unscheduled community health and social care;
- physical co-location of unscheduled health and social care staff to facilitate integrated response and to reduce duplication for the patient;
- a maximum response time of 2 hours 7 days a week across the 24 hour cycle;
- holistic assessment of patients' health (including mental health)and social care needs in their home setting followed by:

- rapid deployment of domiciliary care, nursing, therapy and equipment services with the aim of stabilising the patient and identifying ongoing care needs;
- an increase in evening and overnight staffing in health and social care teams (including at weekends) to ensure that there is prompt response and continuity of care for frail older people in crisis;
- a continuous cycle of reassessment and evaluation over the next 72 hours with close cooperation from the patient's primary care team.

Planned discharge from the Unscheduled Care Team will be into:



The discharge plan will address any outstanding interventions relating to environmental safety and safeguarding, health interventions such as missing vaccinations, medication-related issues and mental health or cognitive concerns with details of how these will be followed up.

The BCF investment in this element – the joint Health and Social Unscheduled Care Team - specifically accelerates the following elements of our model described below:

- uplift and development of the capacity of the Unscheduled Integrated Community Health Services Team and development of integrated pathway for joint response with rapid response social care team (ICRS);
- increase in the capacity in Overnight Nurse Service – to work side by side with ICRS;

- increase in the capacity of Adult Social Care Rapid Response team (ICRS) – for both day and overnight rotas to work jointly with unscheduled health care team;
- co-location of both Health and Social Care Unscheduled Care Teams to develop integrated working, joint visiting and sharing of intelligence and skill sets;
- increase in investment in Assistive Technology and Practical Help at Home teams. Minor home adaptations and equipment and Assistive Technology devices can be key facilitators of independence and safety at home for older people.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities Reduction in premature mortality Reduction in barriers to access	More people will be referred to their own GP practice for further care planning and assessment of needs
Support independence for people with LTC/older people/people with dementia	More people will be treated in their own homes, with no acute intervention More people will be able to remain independently at home Reduction in the numbers requiring permanent admission to residential care More people will be directly referred to the Planned Care Teams and/or their GP practice Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions • A&E reductions in activity at UHL, both in expenditure and activity • reductions in emergency admissions from care homes • reduction in emergency readmissions Less people will require permanent admission to residential care Less people will be delayed in a hospital bed due to a

	lack of community services

Figure 7: Key impact measures of this intervention

Intervention 6: The system coordinator

As our enhanced community based services and pathways have developed over the last few years, a variety of both in-patient intermediate care type facilities and intensive domiciliary services have been commissioned. The challenge remains to ensure that the total available capacity in the community – in-patient and domiciliary, health and social care, NHS and independent sector – is used to optimum (not necessarily maximum) capacity throughout the year **and** throughout the 7 day cycle.

The role of the system coordinator is to act on behalf of the whole health and social care economy across the city – including our acute provider - to ensure that our entire community in-patient bed stock and our total resource for intensive and/ or urgent domiciliary support is being utilised in such a way as to:

- support flow through the system;
- take pressure off the acute sector by facilitating discharge and reducing inappropriate admission;
- ensure that patients are managed in the least intensive setting consistent with their meeting their treatment and therapy goals safely.

Skilled nurse leadership is fundamental to the achievement of integrated care and to the optimal functioning of the total health and social care community based resource. The system coordinator will achieve this through:

1. Bed and other resource management at whole system level outside of UHL – and close liaison with UHL bed manager on twice daily or more frequent basis;
2. Providing input into decision-making processes (for example challenging decisions to keep patients in hospital where there is a lack of knowledge about what can be offered in the community setting);
3. Clinical leadership;
4. Proactive communication with all partners. Providing patient care to ensure that resources are freed up in a timely manner and that where a chain of patient moves through several services is required to happen in order to ensure that each patient is treated in the right place at the right time; that such moves occur in a timely fashion.
5. Leading a twice daily conference call with UHL, LPT CHS and Adult Social Care to coordinate the discharge planning and movement between services from UHL into the community and between various community services.
6. Providing a series of ward based education opportunities over the course of the winter 2014-15 periods to UHL staff on base wards to educate them as to the

capacity of community services to support patients with quite complex needs at home.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Support independence for people with LTC/older people/people with dementia	Less people will be delayed in a hospital bed due to a lack of community services More people will be treated in their own homes, with no acute intervention More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required Reduction in the numbers requiring permanent admission to residential care More people will be directly referred to the Planned Care Teams and/or their GP practice Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions • A&E reductions in activity at UHL, both in expenditure and activity • Reductions in emergency admissions from care homes • Reduction in emergency readmissions Less people will require permanent admission to residential care

Intervention 7: Intensive Community Support

Intensive Community Support is a model of care underpinned by the principles of comprehensive geriatric assessment (CGA), which has a strong evidence base for improving outcomes for older people. The CCG piloted the use of a small number of these beds in 13/14 and following evaluation this will be increased to 30 ‘virtual ward” beds using the BCF investment in 14/15. This which allow patients with complex health and social care needs and relatively high levels of dependency to be stabilised and re-abled at home and access the other elements of our integrated care model easily.

The model of care

A patient-centred and holistic approach to providing intensive integrated health and social care to patients with long term conditions and /or frailty syndrome through intensive community nursing, therapy and social care input to patients in their own homes.

- The service will operate from 8 AM - 10 PM, 7 days per week.
- Treatment and care will be delivered to the patient in their own home but on a more intensive and extended scale than is the case with routine community nursing care.
- Patients will be able to receive up to four visits per day from health and social care staff and are kept on with the ICS for up to six weeks.
- For those patients with overnight monitoring or care needs care after 10PM will be provided by the increased night nursing capacity commissioned via the BCF investment – working side by side with the Unscheduled and Planned Care Teams.
- Although the team will be led by an advanced nurse practitioner, there will be access to the community consultant geriatrician in the Rapid Intervention Team for additional clinical input if required as well as community mental health teams as required.

The ethos of ICS care is rehabilitative where possible and therefore dedicated occupational and physiotherapy staff contribute to assessment and treatment of patients – working in partnership with domiciliary care staff to restore independence in activities of daily living.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities Reduction in premature mortality Reduction in barriers to access	More people will be referred to their own GP practice for further care planning and assessment of needs
Support independence for people with LTC/older people/people with dementia	Less people will be delayed in a hospital bed due to a lack of community services More people will be treated in their own homes, with no acute intervention More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required

	Reduction in the numbers requiring permanent admission to residential care More people will be directly referred to the Planned Care Teams and/or their GP practice Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions • A&E reductions in activity at UHL, both in expenditure and activity • Reductions in emergency admissions from care homes • Reduction in emergency readmissions Less people will require permanent admission to residential care

Figure 8: Key impact measures of this intervention

Intervention 8: IT integration

The incorporation of the NHS number into the social care record has been identified as one of the main strategic priorities in relation to the BCF and is a national condition. It is also one of the core metrics identified by the Better Care Fund Guidance. To develop the delivery of more seamless and integrated health and social care for those with complex needs a single unique identifier will be required where records are to be shared to improve communication across the local health and social care economy.

This scheme is fundamentally concerned with developing a technical and information governance infrastructure across health and social care in Leicester. The system integration project is aimed at meeting the national condition of data sharing through enabling the NHS number to be used as the primary identifier. It will also have the potential to support each of the key projects to integrate its business process and information sharing to an optimised level. This will bring capability for the generation of integrated management information to support strategic and operational decision making.

Phase 1

Phase 1 will firstly involve the development of an overarching information governance framework between the NHS Leicester City and Leicester City Council Adult Social Care. This will allow the sharing of information and the development of a set of associated Individual Information Sharing Agreements (ISA) to support particular functions/services as they integrate more closely in a phased way, in line with the wider programme. Compliance with the IG toolkit is an activity in this phase and a key enabler to allow phase 2 to commence. The establishment of NHS numbers through the Demographic

Batch Service (DBS) for all customers known to Adult Social Care is a key milestone for this phase and is a key enabler in supporting; strategic and operational decision making, service redesign and understanding performance across functions of the integrated care pathway.

Phase 2
This phase aims to build an integral link between NHS and Council information systems respectively. This will facilitate a long term solution to enable day to day transfer of the NHS number and other Personal Demographic data from the NHS SPINE to the Adult Social Care case management system namely Liquid Logic IAS. This link will involve dedicated technical work with the deployment of specialist software modules which are designed to support this type of integration.

What will this mean for our citizens?

This intervention does not have specific measurable targets; rather, the success of the scheme will be judged on the outcomes noted across health and social. For example, we would expect that Information sharing should

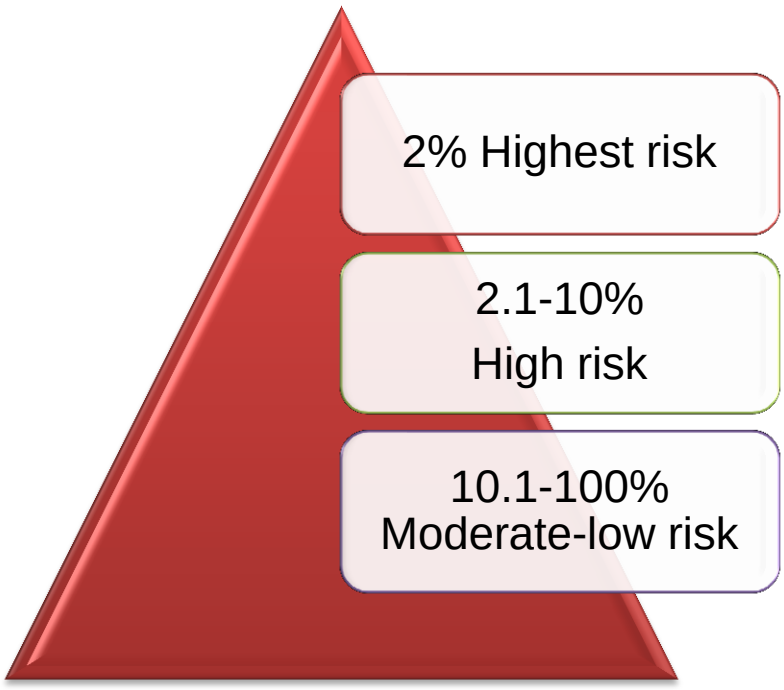
- Facilitate seamless delivery of care across both Health and Social Care economies;
- Increase speed of communications/referrals between integrated functions across the Health and Social Care economy;
- Support systematic tracking of customer journey across Health and Social Care boundaries providing the platform for integrated management information which will support strategic decision making;
- Prevent duplication or inaccuracy across patient / customer records;
- Enhance data integrity in Adult Social Care systems resulting in trusted information to inform decision making both strategically and operationally.

These will be managed by the BCF Implementation Group as well as via the LLR IM&T group to ensure alignment across the wider system.

Priority 3: Enabling independence following hospital care				
Public health need	Intervention	Impact on system		Impact on patients
		2 Year	5 Year	
We know that: Leicester City patients stay in acute beds for longer than necessary on average Dementia patients stay in acute beds for up to 7 days longer than the average Mental health patients stay in acute beds for up to 7 days longer than the average Capacity in primary care for coordination of care for physical or mental health is stretched	Planned Care Team A joint health and social care team, designed to keep patients safely at home and avoid an emergency admission or discharge safely back home. 2 weeks of holistic care provided, with ongoing referral to GP if required	Reduction in bed base	Reduction in bed base	77 year old female identified via risk stratification system as having a relative risk of 7.4 (likely to use 7.4 times the CCG average of health care resources) with a probability of emergency admission of 32.1% . History of chronic Schizoid disorder, bilateral arthritis of hips and knees), depression, and COPD. Has had 4 emergency admissions of 0-2 days and a further 5 ED attendances in the last year – all with presenting symptom of chest discomfort. Recent emergency in-patient admission to mental health ward for assessment following acute episode of symptoms associated with mental health diagnosis. Patient's discharge planning was supported by new mental health social worker for discharge. This resulted in planned discharge to community mental health bed for a period of planned step down care focusing on 4 things • wound care to heal skin tear sustained during period of acute ill-health; • further medication titration for mental health symptoms; • assessment of home circumstances and ability to safely manage activities of daily living; • a structured programme of CBT to help the patient manage symptoms of anxiety related to worry about the significance of transient non-cardiac chest pain. During the next two weeks the patient's home has a number of minor adaptations made by the LA Practical Help at Home Team and the patient undergoes assessment and intervention with the occupational health team. She returns home with follow up from a Community Mental Health Practitioner. She has had no further ED attendances to date and her mental health symptoms are stable.
	Mental Health Discharge Team Support to enable discharge of patients on mental health acute wards. Includes liaison across health and social care and allied services such as housing and finance	Reduction in mental health bed base	Reduction in mental health bed base	
	Mental Health Step Down Service 6-8 beds in a community setting to provide step down from acute episode of care	Increase in community MH bed base	Reduction in acute MH bed base	

The target population for this priority area

The BCF cohort in its entirety will be targeted by the interventions listed in this priority area.



The interventions targeted to this priority area

Intervention 9: The Planned Care Team

The Planned Care Team is a new joint health and social care team which provides ongoing support to patients discharged from the unscheduled care services across the system. Patients will be cared for in their own homes for up to 2 weeks by a multi-disciplinary team of practitioners across health and social care with direct links back to the patient's own GP practice.

This team will provide:

- Deployment at scale of proactive community interventions to reduce risk of admission in those with LTCs (care planning and patient education) and to reduce incidence of preventable admission for ambulatory care sensitive conditions.

- Care coordination for the most complex older people through our Care Navigator team – targeted to coordinate the health and social care services deployed to the frailest cohort of the over 75s. This team will have access to read and entry access to both the health and social care electronic record systems to facilitate joined up communication for the most vulnerable and complex patients. We have identified at least 18 different health and social care agencies and services that the Care Navigators can refer into on behalf of their patients.

- Co-terminus health and social care neighbourhood boundaries to facilitate more integrated working via multi-disciplinary team meetings hosted by primary care and greater continuity of care for those with complex health and social care needs.

- Increased access to adult social care services though the Single Point of Contact (SPoC)

- Increased Adult Social Care Locality staff to facilitate more community assessments and sign posting to advice, information and guidance. The proactive identification of greater numbers of patients at potential risk of admission will require more capacity in ASC locality teams to deliver timely responses to requests for non-urgent help.

- Up to 6 weeks of free access to reablement services will be offered to all those who might benefit. Reablement will aim to optimise the functional independence of older people at home by providing therapy and equipment as needed to promote achievement of agreed therapy goals. In addition part of the planned health care provision will include a community nurse assessment on entry into reablement as standard.

The BCF investment in this element – Planned Care Health and Social Care teams - specifically enables the following elements of our model described below:

- uplift and development of the capacity of the Community Mental Health Practitioner team to proactively address the needs of older people's mental health in the community;
- establishment of a new Care Navigator Service – a team of health and social care coordinators to coordinate health and social care services for the frailest over 75s;
- increase in the capacity of Adult Social Care (ASC) Single Point of Contact (SPoC) to facilitate alignment of their working times of the Health Single Point of Access (SPA);
- year long process of organisational development by Leicester City Adult Social Care Services to redesign their current locality boundaries to align them to be co-terminus with the neighbourhood structure of Leicestershire Partnership Trust Community Health Services.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities Reduction in premature mortality Reduction in barriers to access	More people will be referred to their own GP practice for further care planning and assessment of needs

Support independence for people with LTC/older people/people with dementia	Less people will be delayed in a hospital bed due to a lack of community services More people will be treated in their own homes, with no acute intervention More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required Reduction in the numbers requiring permanent admission to residential care More people will be directly referred to the Planned Care Teams and/or their GP practice Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions; • A&E reductions in activity at UHL, both in expenditure and activity; • reductions in emergency admissions from care homes; • reduction in emergency readmissions. Less people will require permanent admission to residential care

Figure 9: Key impact measures of this intervention

Intervention 10: Mental health discharge support

In order to meet the demand identified and to negate any detrimental impact on patients, this intervention will increase the capacity of the social work assessment team on two key units:

1. The Bennion Ward (mental health services for older people)
2. The Bradgate Unit (adult mental health)

It is envisaged that these posts will work in partnership with the Unscheduled and Planned Care Teams described earlier in this plan to ensure that holistic care is provided for these patients.

Delays to discharge attributable to housing have also been a long-standing problem with the inpatient service at the Bradgate Unit. Aligned to this intervention, LPT has worked

with colleagues in the city to develop plans for a 6 month pilot whereby dedicated housing support posts are available, based at the Bradgate unit. It is intended that this will enable quicker processing of applications and will facilitate innovative solutions to be implemented where there is a shortage of suitable accommodation available. The pilot also includes the establishment of a small fund, which will provide rent deposits and essential furniture, where this is a barrier to discharge. The pilot will be hosted by Blaby District Council on behalf of LLR. The pilot also includes a support post, which will ensure service users are supported as they make the transition from hospital into their new accommodation.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities Reduction in premature mortality Reduction in barriers to access	More people will be referred to their own GP practice for further care planning and assessment of needs Improved quality of care within MH inpatient units by being able to focus on patients who are medically unwell as medically fit patients are discharged more quickly Mental health patients will be able to access a range of integrated care services as easily as those with physical health through the increased staffing provision
Support independence for people with LTC/older people/people with dementia	Less people will be delayed in adult MH and MHSOP inpatient wards due to a lack of knowledge of community support More people will be treated in their own homes, with no acute intervention More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required More people will be directly referred to the Planned Care Teams and/or their GP practice Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions; • A&E reductions in activity at UHL, both in

	expenditure and activity; • reductions in emergency admissions from care homes; • reduction in emergency readmissions. Less people will require permanent admission to residential care

Figure 10: Key impact measures of this intervention

Intervention 11: Integrated Mental Health Step Down Service

LPT have been working with the InMind Healthcare Group over recent months to develop a proposal with them to provide a step down facility from Sturdee Community Hospital (Eyres Monsell). It will be for service users leaving the acute inpatient unit and aims to ease bed pressures at the Bradgate Unit, by offering support to service users making the transition from acute care back in to the community.

The current proposal involves LPT commissioning 6-8 step down apartments from InMind Healthcare Group. The service will receive referrals from the Bradgate Unit acute wards for low risk individuals who could benefit from the opportunity to function semi-independently in the community, prior to discharge from hospital. The service is provided within a hospital setting, and patients will be under the care of the medical and nursing staff at InMind. The anticipated length of stay for individuals is 14 to 28 days.

The service aims to:

1. Provide a short term step down facility that promotes independence, inclusion and community engagement for service users, following an episode of acute mental illness;
2. Facilitate a successful and sustainable discharge from hospital, back in to the community for service users;
3. Facilitate reduced lengths of stay within LPT acute inpatient beds;
4. Provide a cost effective service that meets the needs of service users who no longer require the intensity of support provided within an acute ward.

What will this mean for our citizens?

Health &/or wellbeing need:	Impact of this intervention on patient outcomes:
Reduction in health inequalities Reduction in premature mortality Reduction in barriers to access	People will have a greater choice of services available to service users at the point of crisis People will have a greater ability to access support swiftly and directly when they feel they are reaching crisis point

	Inpatients will have access to better support making the transition from acute care back to the community and developing their skills for independence
Support independence for people with LTC/older people/people with dementia	Less people will be delayed in adult MH and MHSOP inpatient wards due to a lack of knowledge of community support People will have access to quicker processing of housing applications and the sourcing of suitable housing for inpatients preparing for discharge More people will be treated closer to their own homes, and not at a distance from their friends and family More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required More people will be directly referred to the Planned Care Teams and/or their GP practice Less reliance on acute activity, evidenced by: • QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients, A&E and emergency admissions; • A&E reductions in activity at UHL, both in expenditure and activity; • reductions in emergency admissions from care homes; • reduction in emergency readmissions. Less people will require permanent admission to residential care

Figure 11: Key impact measures of this intervention

This intervention is part of a wider transformation of the mental health pathway across the city.

This integrated model of delivery will enable us to achieve what we set out originally to do: work together with communities to improve health and reduce inequalities, enabling

children, adults and families to enjoy a healthy, safe and fulfilling life and will also enable the delivery of the nationally set outcomes of the BCF programme:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience
BCF Local Metric: More people being identified as living with Dementia

These are outlined in more detail in template 2 of this submission.

2b) What difference will this make to patient and service user outcomes?

We recognise that our previous model of care provided unaffordable and variable quality of care, placing a high demand on the acute sector. Our resources were concentrated on crisis and statutory services, rather than services designed to keep people independent and this contributed in part, to too large a variation in health outcomes across the city.

As outlined in each priority area above, each intervention has been designed specifically to impact directly on the local public health needs and the broader demographic and socio-economic issues identified in both our JSNA and HWB strategy.

Many of the interventions have been enabled by the creation of a BCF in 2014/15 to prepare for full implementation in 15/16 and this is already having an impact on our patients as evidenced by the case study below of a real City patient in August 2014:

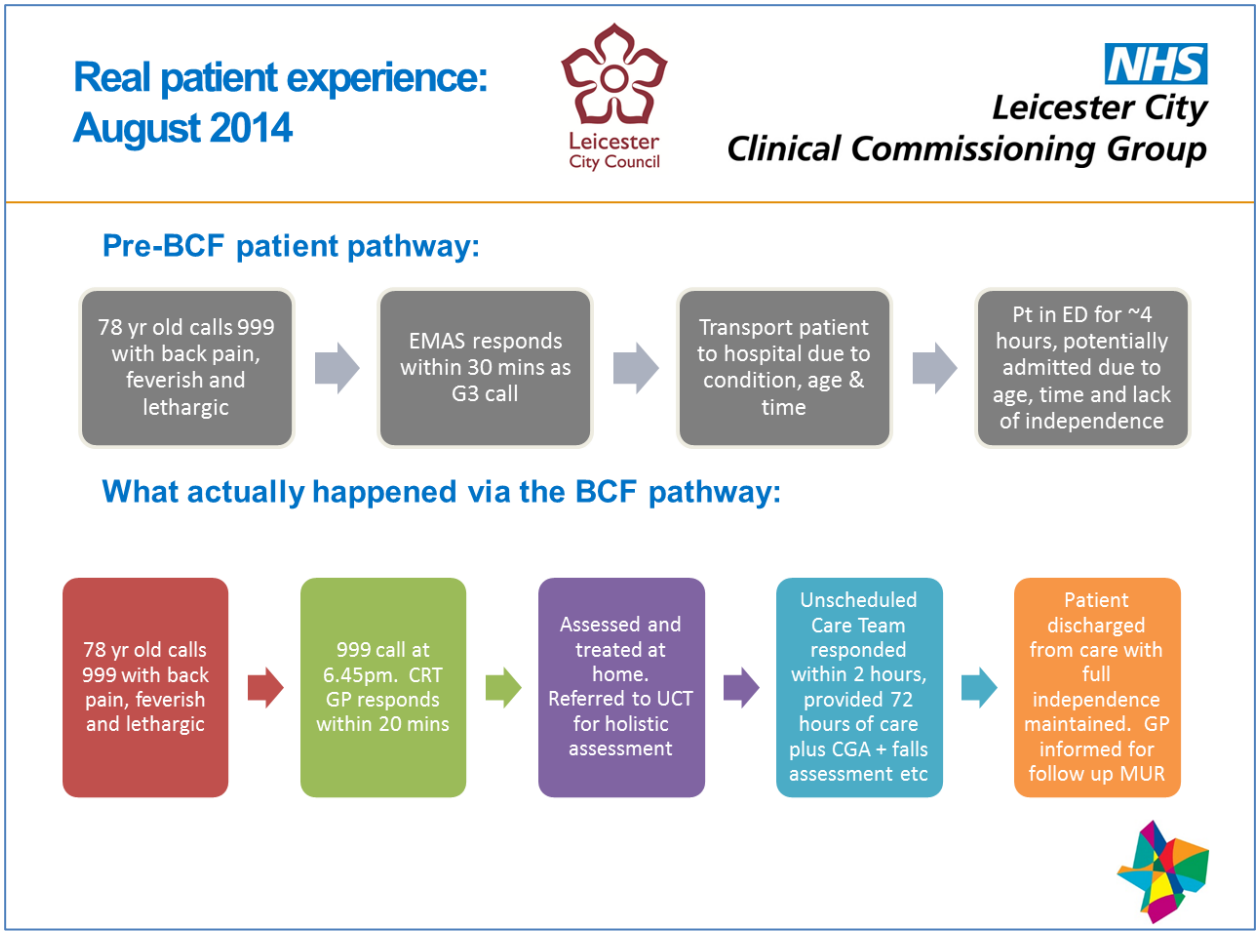


Figure 12: A real patient story from August 2014 presented at the Leicester City Protected Learning Time event for our general practices

The National Voices document *Person Centred Care 2020 (September 2014)* suggests that the system wide characteristics presented in column 1 below should be demonstrated by 2020; the second column outlines the impact on our patients and service users:

Characteristic	The Leicester City BCF will achieve this by 15/16 through delivery of:
Much greater emphasis on promoting health and preventing illness, especially for those most at risk.	5,000 people will be referred to primary prevention services at the Lifestyle Hub
	7,200 care plans completed for the highest 2% at risk patients
	16,921 care plans completed for the highest 2.1-10% at risk patients
	4000 GP-led sessions delivered in primary care to deliver targeted care plans for high risk patients
	2,100 people will be cared for by a Care Navigator
	Approx. 2,000 emergency admissions will be avoided providing GP response
	Health and social care systems will be aligned, with the NHS number in use by December 2014

	Approx. 25,000 people will be assessed by the joint Health and Social Care Unscheduled Care team each month, ensuring the services are delivered in the citizen's place of residence where appropriate
	Approx. 8,000 people will be assessed by the joint Health and Social Care Planned Care team each month, ensuring the services are delivered in the citizen's place of residence where appropriate
	205 less people will be admitted to permanent residential care due to the support provided in the community
	Joint 7 day community health and social care services to keep citizens out of hospital will be the norm, rather than the exception
	Readmissions will have been avoided by efficient discharge processes and subsequent appropriate management of care in the community
	Delayed transfers of care will reduced through the provision of high quality care packages at appropriate times
	Length of stay, specific to mental health, will reduce to the national average of 30 days with the support of MH specific discharge facilitators
	Housing issues will not be a barrier to discharge for either physical or mental health conditions through the new joint teams, including housing support
What really matters to people will be a key outcome	The JICB will continue to explore outcomes based commissioning options, ensuring that regulatory, financial and organisational priorities do not impede person centred delivery models of care
	User experience metrics will be key to informing future service provision
Agencies with an impact on health and care will increasingly work together	The CCG and the Local Authority will continue to work with partner agencies across both the city and surrounding areas to ensure the design and delivery of care is seamless, no matter where our citizens access care.
Voluntary and community sector organisations (VCS) will be full partners in the design and delivery of person centred care	VCS organisations will have had a clear opportunity to co-produce elements of the BCF, both in terms of design and delivery.
Statutory services will support and enable the "informal workforce"	The Citizen Participation Strategy will promote the work of the informal workforce, encouraging more participation through specific community events, using the NHS 'winter friends' model. 500 winter friends will be recruited per winter period.
	1000 dementia champions and friends will be recruited to promote the assessment, management and support of people with dementia and their carers

Patient experience of care

We will also measure the experience of our patients through our patient experience metrics, both at a strategic BCF Programme level as well as through individual project metrics focussed on patient experience.

Our strategic patient experience metrics have been agreed locally through the BCF Implementation Group. We have chosen patient experience metrics covering each part of our integrated model of care in order to test each component part.

CQC Inpatient Survey	GP Survey	Adult Social Care Users Survey
Q64. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	(For respondents with a long-standing health condition) Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health	3a. Which of the following statements best describes how much control you have over your daily life?

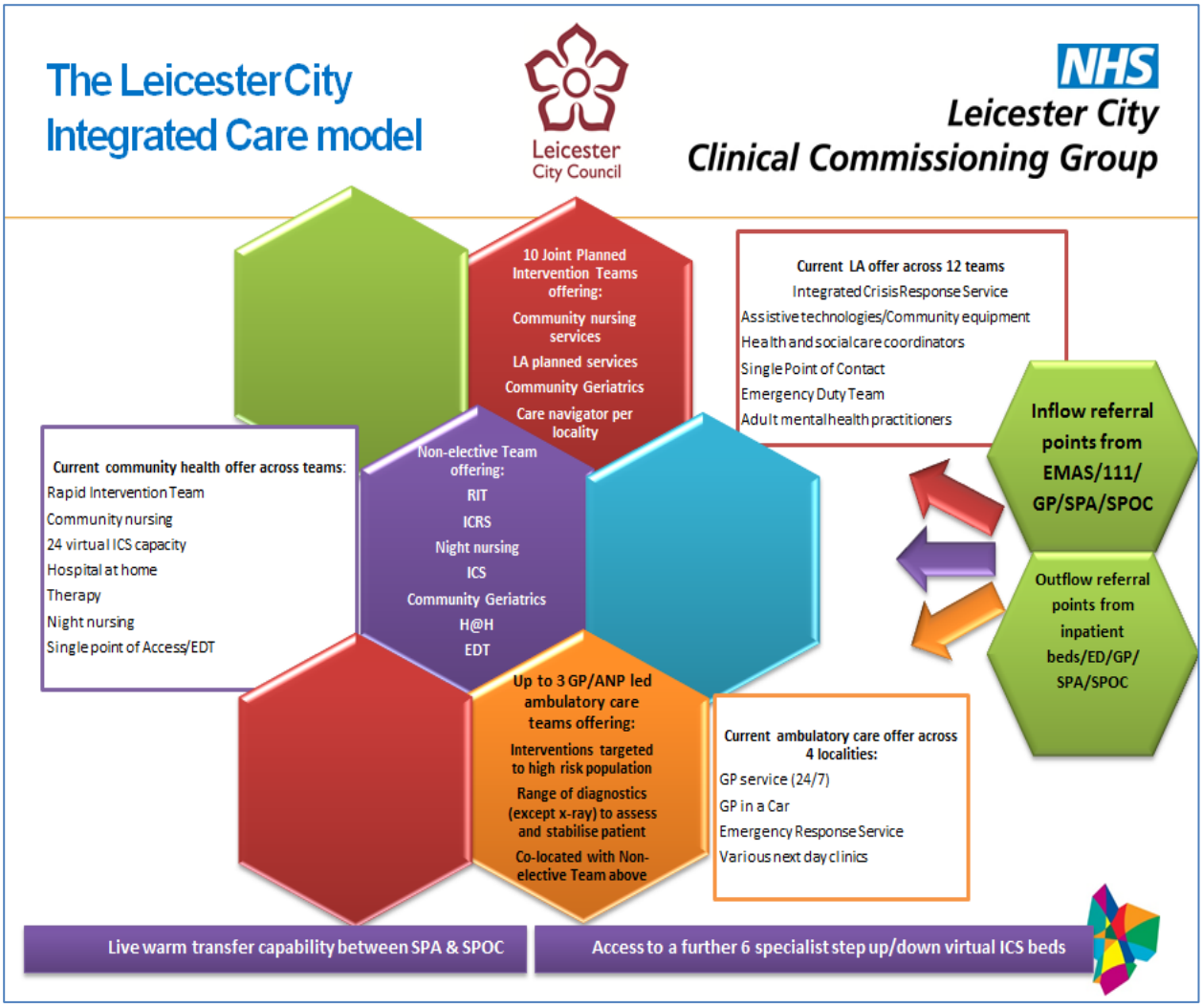
Measurement of these metrics will enable us to ensure that the experience of our target group is positive, with outcomes being improved and services being delivered around patient needs.

Each project also has patient experience metrics appropriate to the project. These will be measured more frequently than the national metrics to ensure a robust test of the system from a patient perspective.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The resultant model of care

At a local level, by joining up our services from the bottom up we will make a fundamental change in both culture and delivery mechanisms within our local health and social care economy, resulting in a joined up system across health and social care:



This model will result in a significant shift in activity which has traditionally been delivered through the acute sector to a modern model of integrated care, provided at scale in the community. We expect this new model of integrated care to change patient flows to the extent that in five years, we will have seen up to a 15% reduction in the form and function of the acute sector and a significant growth in the services offered in the community.

This transformative change in form and function, while keeping with each organisation's individual responsibilities, will change the landscape of all future commissioning of integrated care models for our city. We will not let traditional boundaries stop us from progressing towards our vision of whole-scale transformational change.

Which aspects of this change will be delivered through the BCF?

The Leicester City Better Care Fund has been used to significantly accelerate the mobilisation of the local integrated care pathway. We started our journey towards integrated care in 2013/14, with a clear vision of how we wanted the services to work seamlessly together for the benefit of our patients. The BCF has enabled a sub-set of these plans to be fast-tracked into mobilisation through 14/15 and 15/16 combined with a set of new interventions mobilised as part of the new BCF programme.

Intervention	Status	How has the BCF contributed to accelerated mobilisation?
Risk stratification	Acceleration	Enabled further functionality of the system which will be used to change the pattern and configuration of future service provision
Lifestyle Hub	Acceleration	Enabled extension of the Hub to City wide in 15/16
GP practice scheme	Acceleration	Enabled 2.1-10% of the high risk population to be provided with enhanced support
Clinical Response Team	New	New scheme, funded entirely through new BCF funds
Unscheduled Care Team	Acceleration	Enabled full co-location of teams, as well as increased capacity in both social care and health sections of the team
System integration coordinator	New	Enabled a joint integrated system wide flow coordinator funded entirely through new BCF funds
Intensive Community Support Service	Acceleration	Enabled significant upscale of service, with 30 virtual beds added to community service provision
IT integration	New	Enabled the NHS number as a primary identifier across health and social care
Planned Care Team	Acceleration	Enabled full co-location of teams, as well as increased capacity in both social care and health sections of the team
Mental Health Discharge Team	New	New scheme, funded entirely through new BCF funds
Integrated Mental Health Step Down Service	New	New scheme, funded entirely through new BCF funds

These interventions will continue to deliver the changes required to deliver systematic change over the next five years.

This programme is purposely aligned with longer-term strategic changes planned across the Leicester, Leicestershire & Rutland health and social care economy. This is coordinated through the Leicester, Leicestershire and Rutland *Better Care Together* programme and our plans will be a key enabler to the Leicester, Leicestershire & Rutland five year Strategic Plan.

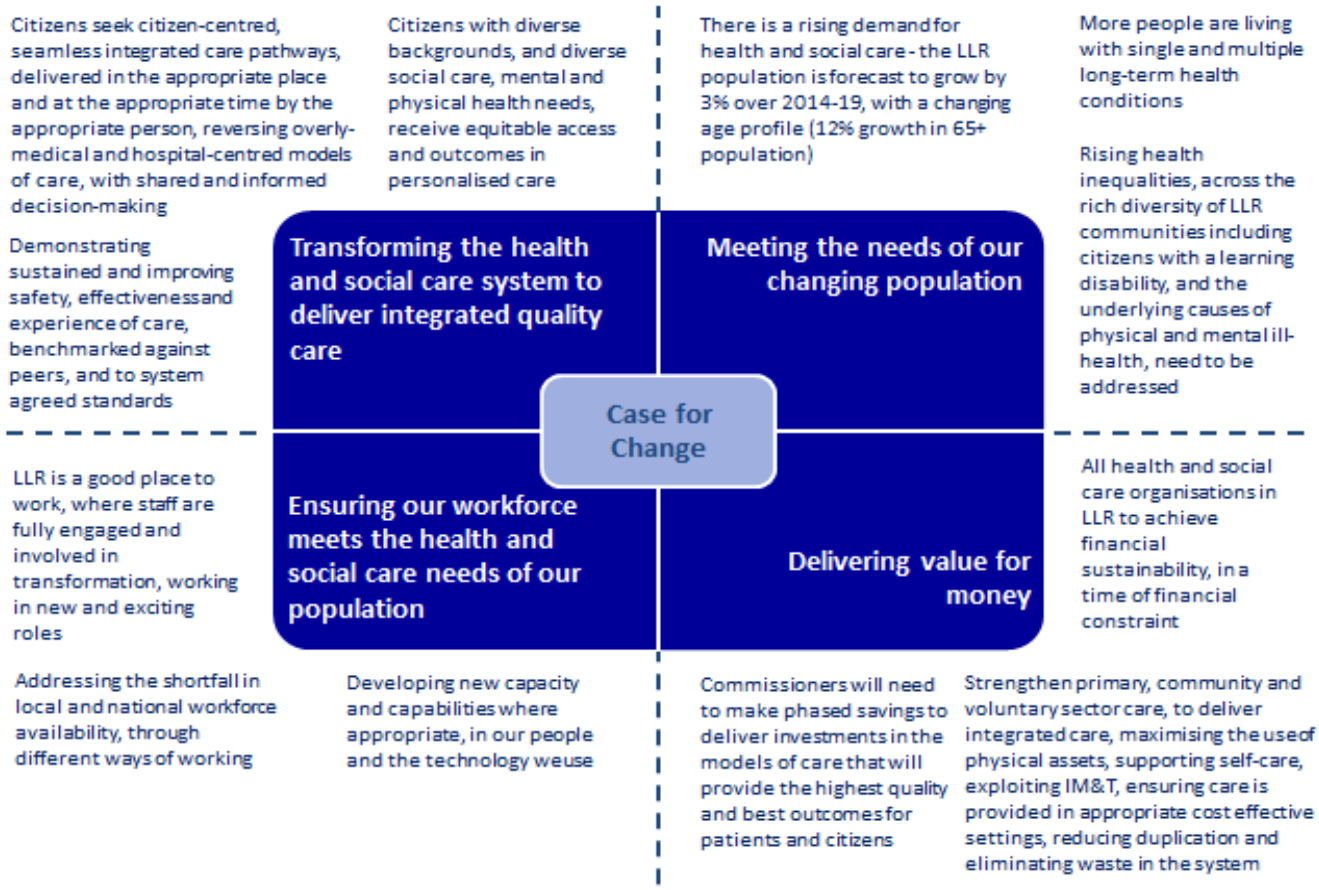
3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Everyone Counts: Planning for Patients 2014/15 to 2018/19 sets the overall medium term planning framework for the NHS and describes what the NHS must deliver to patients nationally. The NHS 'Call to Action' asks all NHS providers and commissioners to respond to the significant challenges facing the NHS in delivering health and care policy into the future, including:

- an ageing society
- the rise of long-term conditions
- rising expectations
- increasing costs of providing care
- limited productivity
- pressure of constrained public resources that the NHS face
- variation in quality of care across the health system.

In June 2014, the LLR wide programme "Better Care Together" published an overarching strategic case for change to respond to these challenges, which has been co-produced across the health and social care system, including via public engagement, illustrated below:



Analysis and modelling which supports the LLR case for change

Across LLR, an integrated long term system model has been constructed for the Better Care Together programme which describes and measures how the system challenges will be addressed. This models the impact of actions/ interventions to improve the quality of services provided to patients and/or improve the financial value of services without quality being compromised.

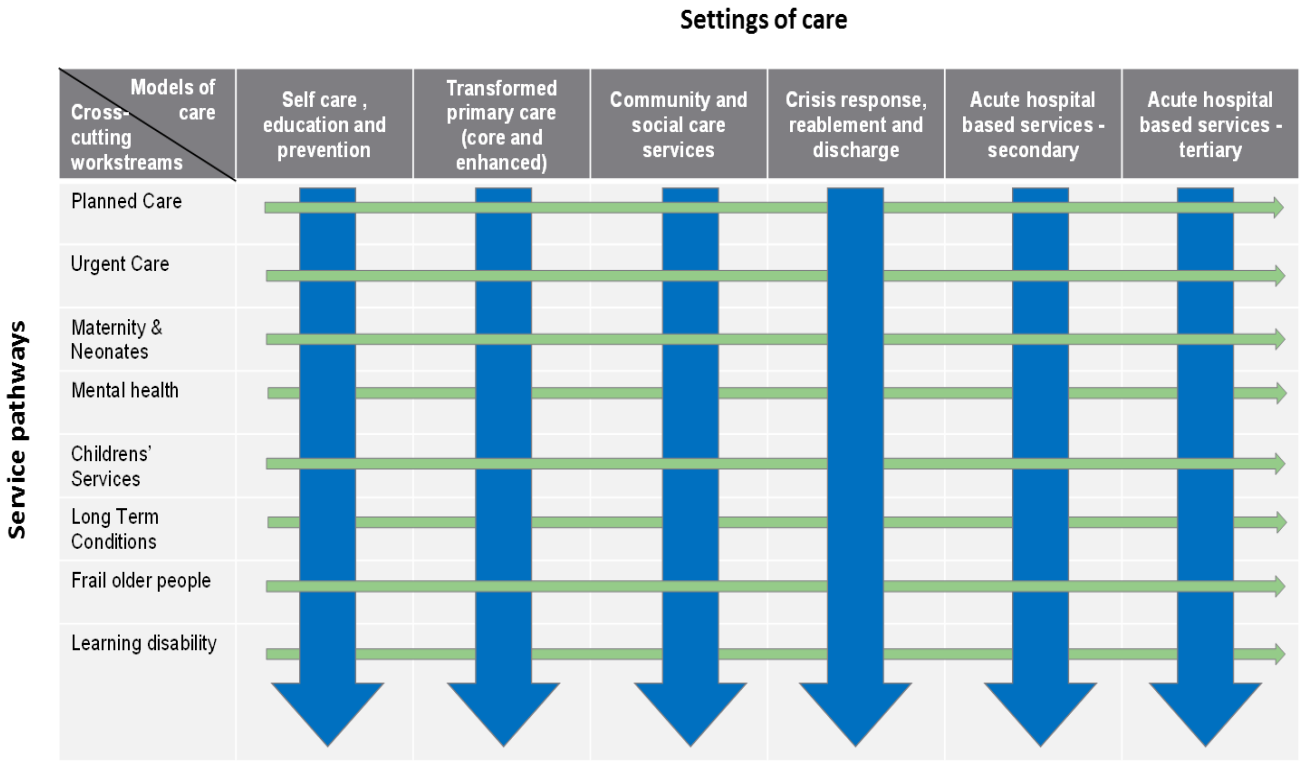
The model has been constructed as an integrated tool based on a shared set of planning assumptions, which are mirrored in the individual plans of constituent organisations. It factors in the financial assumptions of all partners across health and social care economy and illustrates the impact of proposed changes on activity and costs across the system including the impact of:

- implementing new models of care;
- shifting care between settings;
- planned efficiency programmes;
- planned investments across health and social care including those linked to the BCF.

The work to develop the Better Care Together five year strategy has involved analysing and prioritising the case for change in eight main service areas, setting out:

- the main changes that are needed to these service models;
- how care will need to shift across settings in the future.

The matrix below shows the eight service pathways and six settings of care being addressed by the LLR five year strategy.



The Leicester City BCF plan is constructed under three priority themes, in support of the BCT five year plan analysis. The table below show how each theme within the BCF maps to the workstreams and settings of care in the BCT matrix:

BCF Theme	**BCT Matrix**
Priority 1: Prevention, early detection and improvement of health-related quality of life	Self-care, education and prevention Long term conditions Community and social care services Transformed primary care
Priority 2: Reducing the time spent in hospital avoidably	Urgent care Crisis response Community and social care services Transformed primary care Frail older people
Priority 3: Enabling independence following hospital care	Acute hospital based services Reablement and discharge Community and social care services

The Leicester City BCF plan will deliver specific changes in five of the BCT settings of care	**The Leicester City BCF plan will deliver specific changes in three of the BCT models of care**
• Self-care, education and prevention • Community and social care services • Crisis response, reablement and discharge • Transformed primary care • Acute hospital based services	• Frail older people • Urgent care • Long term conditions

Our local evidence based planning process

The approach taken to the development of the Leicester City Better Care Fund has been no different to a normal commissioning process within Leicester City. The NHS Commissioning Cycle has remained the key reference document for the city when commissioning any service:

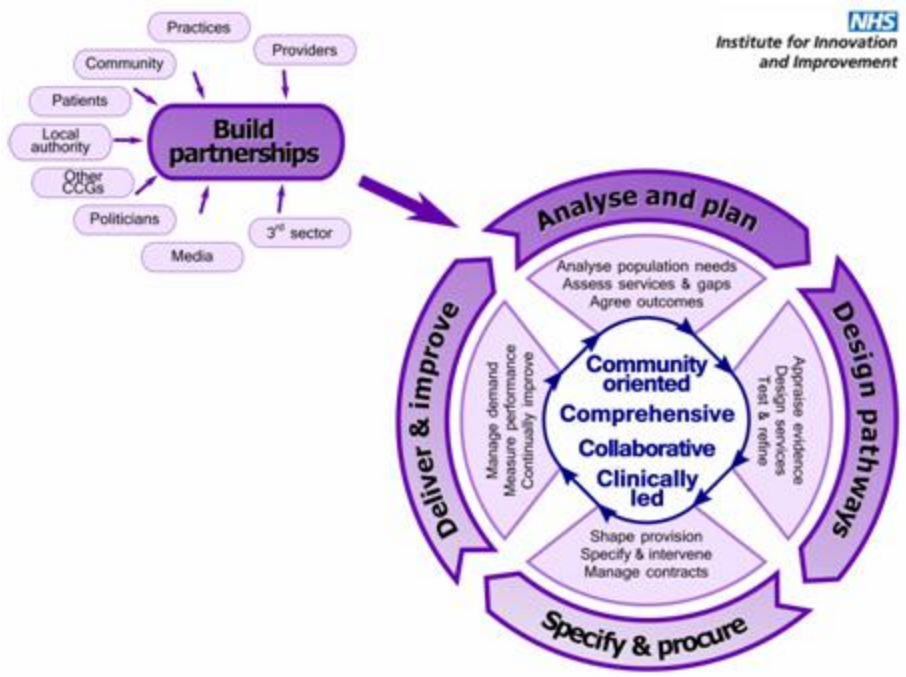


Figure 12: The Clinical Commissioning Cycle, (NHS Institute, 2013)

The key actions detailed in Figure 12 ensure a robust planning process is undertaken and resonates with the 'Four steps for robust planning' outlined in the BCF technical toolkit. Financial analysis and benefits modelling, as described in the BCF toolkit, have been provided as Appendix 2 and 2a.

By enacting these steps, we have strived to create the 'foci of integration' (NHS Institute, 2013) to ensure that integration is fully achieved for the benefits of our patients. This is illustrated below:

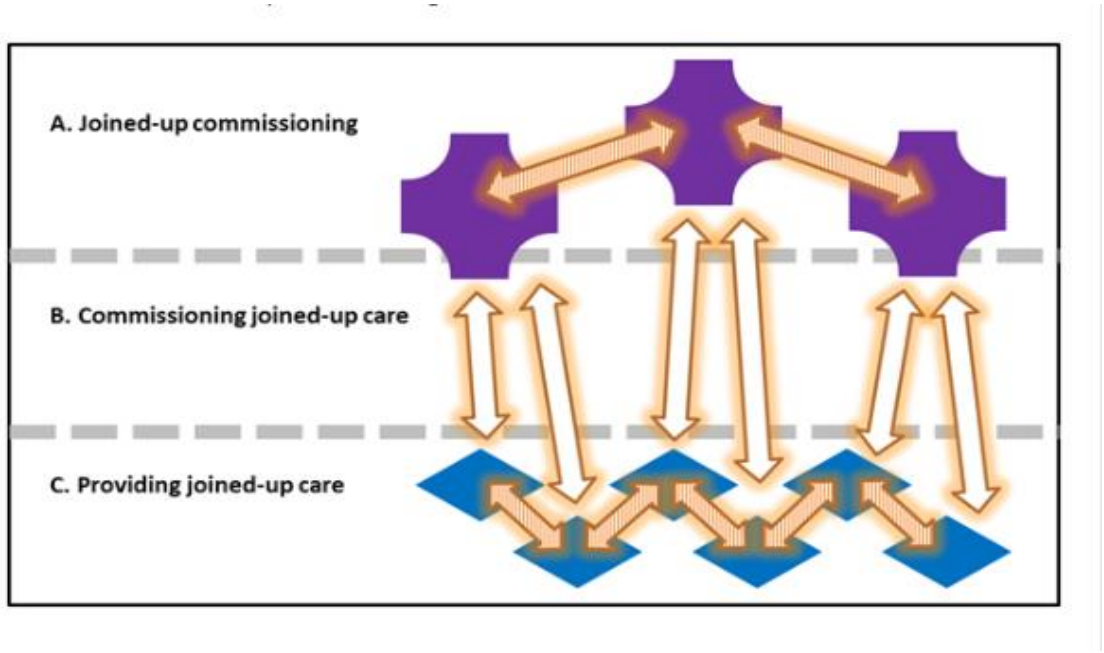


Figure 13: The Foci of Integration, NHS Institute 2013

We will continue to follow this cycle to ensure that evidenced based planning is the driver to achieving real change across the city.

Step 1: Defining our target BCF population: population segmentation, risk stratification and information governance

Information governance

Current information sharing agreements within the Leicester, Leicestershire and Rutland Unit of Planning do not permit the use of aggregated practice data at population level for secondary purposes, and this presents a barrier in being able to progress the risk stratification and population segmentation analysis recommended in the latest BCF guidance.

For the purposes of the BCF resubmission, we have undertaken some initial population segmentation analysis with the support of the Greater East Midlands Commissioning Unit. This has been developed in the format recommended by the BCF guidance and webinar materials, e.g. to show segmentation by age and condition, and has been developed in support of the case for change and evidence base for the BCF interventions with respect to frail older people and those with long term conditions.

The LLR Information Management and Technology programme board, which is part of the governance system for the LLR five year plan is taking the lead with respect to the developments needed locally to improve the data sharing, information management and technological platform for the local health and care system. The status of the current information sharing agreements has already been identified as a key issue to resolve.

An action plan is being developed to address this and will be designed to enable the approach recommended in the BCF guidance to become a routine part of system wide analysis for the health and care economy in the medium term.

The action plan will include:

- a proactive GP practice engagement plan across the primary care sector to promote the need for the changes to the agreements and to work in a coordinated way to achieve this across the whole unit of planning, supported by all three CCGs and the Local Area Team;
- a project plan with clear milestones and responsibilities to authorise new agreements and implement the practical tools and reports needed to enable this data to be generated and applied effectively in LLR, with governance via the LLR IM&T workstream;
- briefings for all three health and wellbeing boards about the rationale and scope of the work to deliver an enhanced approach to risk stratification and population segmentation, showing how this supports not only the BCF related activities but also JSNA refresh activities and the Joint Health and Wellbeing Strategy priority outcomes and work plans.

- The action plan will also be informed by:
    - examples of work and products in areas who have made early progress in this work such as the work in progress in South Central Region Commissioning Support Unit (Examples of the analysis we are seeking to develop in LLR are given in the slides at Appendix 9);

- imminent national regulatory changes affecting section 251 agreements and related information governance matters;
- related work in progress on business intelligence transformation within the County Council including how public health intelligence is developing in conjunction with other departments in areas such as unified prevention;
- the engagement and advice of partner agencies and IG experts across LLR.

From a Leicester City CCG/Council perspective we are progressing the following actions which already form part of the enabling work associated with the BCF:

- Public Health will continue to work with the Greater East Midlands Commissioning Support Unit to develop some initial specific reports on the health needs of the population of Leicester City using the GP held risk stratification data, allowing us to segment our population by different levels of vulnerability, frailty and health and social care needs.
- We will develop the applications of the risk stratification data to improve our understanding of social care needs, with particular emphasis on BCF interventions.
- We will explore the implications of incorporating social care data into the risk stratification tool, allowing us to understand health and wellbeing needs better across the whole pathway of care.
- We have also engaged the National Centre of Excellence for Information Sharing which is hosted by Leicestershire County Council at this early stage in order to influence national developments and access national best practice to shape our approach.

Our approach using risk stratification and population segmentation

Since 2012 Leicester City CCG has supported practices in using the Adjusted Clinical Groups (ACG) risk predictive software (licenced from Johns Hopkins University in the USA) to risk stratify their registered population and identify those at highest risk of admission to hospital in the next year. We have invested in this to enable our practices to proactively identify patients at high risk of admission and apply a Multi-Disciplinary Team approach to their care.

We have used ACG-derived risk stratification, along with other methods of grouping the population outlined in the BCF technical toolkit such as grouping by age and condition, to identify our target BCF cohort, i.e. those patients who are at most risk of deterioration or at risk of a significant care event. Through the provision of high quality, integrated health and social care services, our core aim is to reduce the probability of an emergency admission in this cohort.

Running data through the ACG tool has provided an output that shows the number of people in each risk stratum:

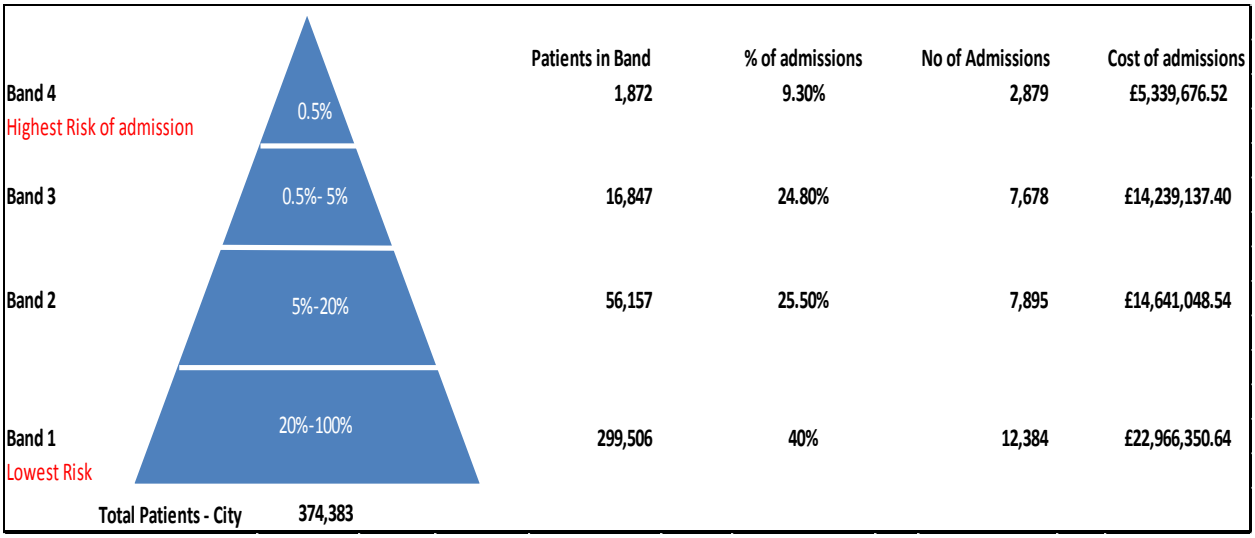


Figure 14: Leicester City CCG Risk Stratification exercise, 2014

As illustrated above, the highest 20% at risk patients account for over 60% of the total cost of emergency admissions for the CCG. Our analysis has also shown us that those patients, regardless of age, who have three or more comorbidities have far more NEL spells at a far greater cost than the rest of the population:

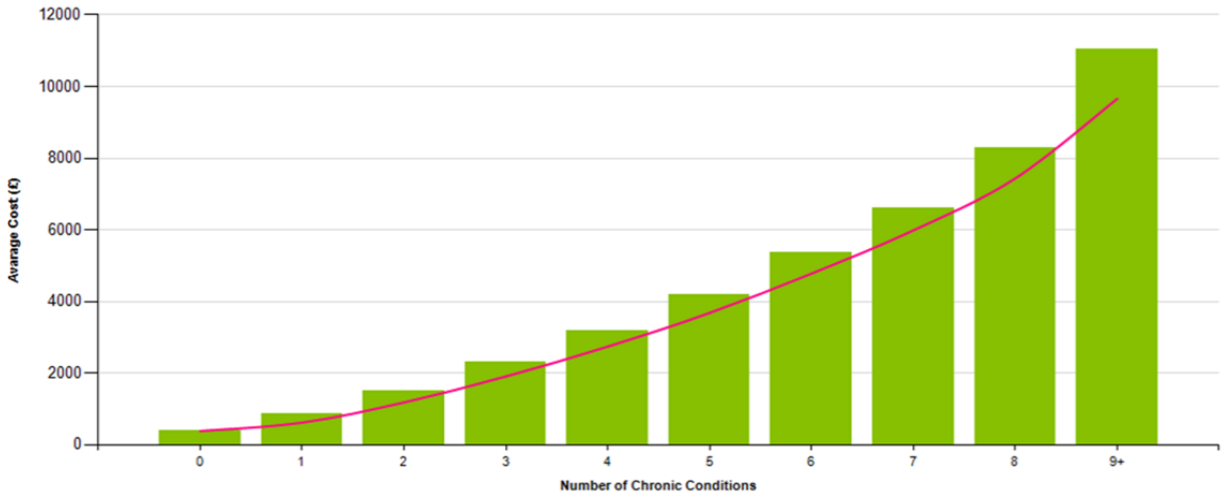


Figure 15: Three or more comorbidities = high usage of acute care and increased cost

We have also analysed data from our GP systems to understand the impact of age and multi-morbidity in these cohorts. As recommended in the BCF technical guidance, this was done at a population segmentation workshop, which included GPs, health and social care commissioners, public health, local providers from acute and community organisations and other local experts in analysis and data segmentation. This workshop looked at various sources of data across both health and social care and mapped these to both the BCF national metrics as well as a range of data from the NHS, ASC and public health outcomes frameworks. National segmentation methodology was also critically analysed with the following conclusions accepted by the group:

1. Academics and clinicians agree that with advancing age comes a higher use of health and social care; however, many national documents and academic papers look at the rising cost of care associated with people who are 75 years and older.

In Leicester City, whilst the average age expectancy is growing, it is still significantly lower than the England average, with life expectancy currently at 74.2 years for men and 81.8 years for women. The rate of improvement compared to nationally is also slower. Put simply, people do not live long enough to use health and social care in these age segments. This, coupled with the cost analysis by age presented previously, had led us to focus on those aged 60 years and over.

2. Given the low health outcomes historically seen in the city, a number of other segments have been assessed as potentially benefitting from integrated care; our analysis shows that the activity and cost associated with the 18-59 year segment of the population rises exponentially once 3+ comorbidities have been recorded. Analysing ACG data from the past year on these segments shows that this segment of the population, whilst smaller in size, has a higher number of emergency admissions at significant cost to the system than the 60+ segment.

3. The workshop participants also agreed that the risk of admission for those patients diagnosed with dementia would also be greatly reduced; we know from local and national sources that patients with dementia are often admitted from ED without a medical need but because there is nowhere else safely for the patient to go, particularly late at night. Also, the length of stay for dementia patients is excessive, with current analysis showing 7 bed days could be avoided if integrated discharge was made available.

Combining these sources of intelligence, leads us to a target BCF cohort of approximately 93,605 patients; this is small enough to be manageable by the BCF interventions but a sufficient number through which large scale change can be evidenced.

Figure 16: Population segmentation by age, multi-morbidity (May 2014)

Combining risk stratification and population segmentation intelligence

We are in the process of allocating the whole population within our segmentation model as described above in the information governance section. Thus far, we have identified our core segments through both population segmentation and then the running of the ACG risk stratification tool across all practices.

For the top 2% highest risk patients we have used the ACG system to create a segment defined as:

- Aged 18+
- Risk of hospitalisation in next 12 months 30%+
- Risk of being in the top 5% highest costing group of patients in LLR 60%+ (this prediction is one of the standard outputs of the ACG system for each patient based on their Adjusted Clinical group cell. Patients are then assigned by the software into one of five Resource Utilisation Bands (RUB). RUBs 3, 4 and 5 have progressively increasing probability of being high cost patients (largely, though not exclusively, due to hospital use as either in-patients, outpatients or ED attenders) and are suitable candidates for proactive intervention by health and social care in the community.
- See the following example of how a patient with diabetes and associated co-morbidities is assigned to their ACG cell and how this maps to a level of health care resource use:

How Morbidity Patterns Affect ACG Assignment (2)

High Cost Patient with Diabetes		
Input Data/Patient Characteristics	**ACG Output**	**Resource Consumption Variables**
Age/Gender: 54/Female	ACG-4930: 6-9 other ADG combinations, age > 34, 3 major ADGs	Total Cost: £1,800 OP Attendances: 6 GP Visits: 10 IP Admissions: 0
Conditions: Diabetes Mellitus, general medical exam, congestive heart failure, thrombophlebitis, contusions and abrasions, non-fungal infections of skin, disease of nail, chest pain, vertiginous syndrome, fibrositismyalgia, respiratory signs/symptoms and cough	ADGs: 01, 04, 09, 10, 11, 21, 27, 28 and 31.	

- three or more ACG defined LTCs
- 0-8 ACG defined “Hospital Dominant Conditions” (i.e. combinations of problems associated statistically with a 50%+ chance of hospitalisation in the next 12 months)
- ACG frailty flag positive as preference (frailty flag is switched on when a patient has one or more conditions highly associated with significant functional deficit – incontinence of urine or faeces, dementia, falls, carcinoma of lung etc.)

This has given each practice a list of their highest 2% at-risk patients (including those under 18 who have complex health problems) and accommodates those with mental health problems as well as physical health disorders – both major and minor. This allows each practice to participate in the national DES for unplanned admissions.

The CCG furthermore has used the ACG system to support the identification of the next highest risk group comprising the segment of the city population in the 2.1-10% highest risk cohort to target for a variety of interventions by health and social care with the aim of increased quality of holistic care leading to fewer unplanned admissions and shorter LOS this winter. While this population is characterised by having fewer hospital dominant conditions and more patients negative for the frailty flag; they are still a relatively high risk segment of the population. Anecdotal feedback from GPs and Practice nurses indicates that this cohort tend to offer greater opportunities for optimisation of their medical management and are likely to benefit from social care assessment.

Analysis of these lists has resulted in the 'typical profiles' for each risk band to be identified to aid planning:

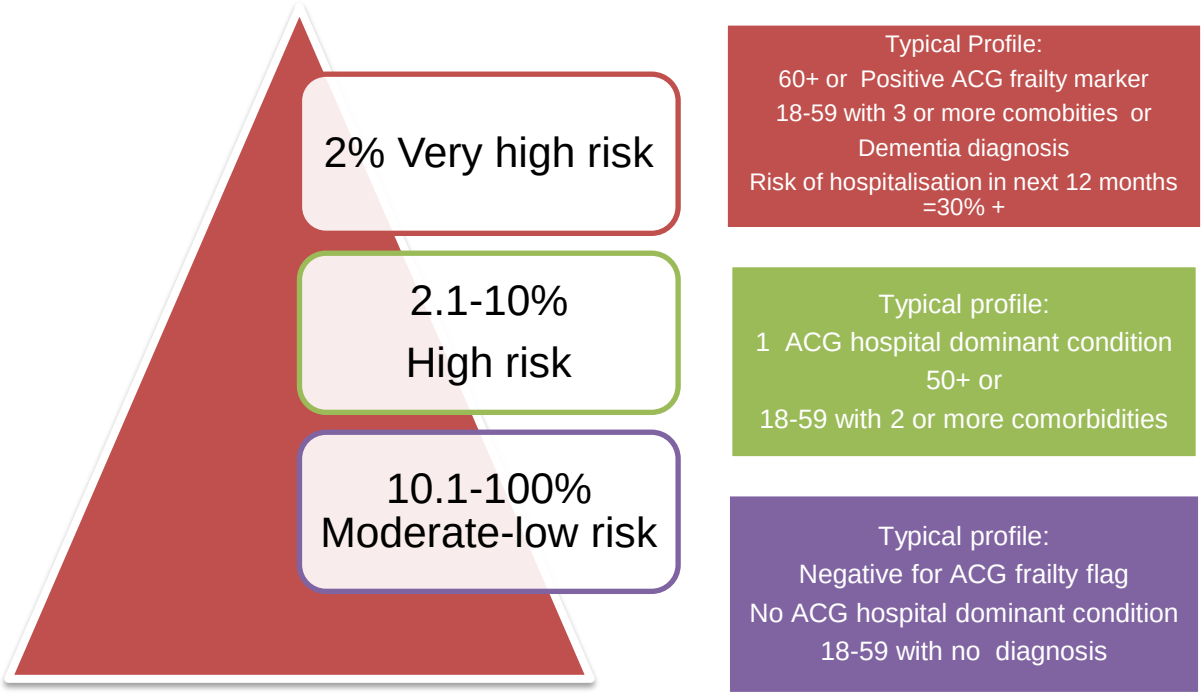


Figure 17: Combining risk stratification and population segmentation intelligence

Once access to the full data is granted, we plan to project our spend by segment for the whole population to inform not only BCF plans in the future but also to drive core commissioning.

Step 2: Understanding the evidence for this population

The evidence base used for each priority area is outlined in each section below. This broadly resonates with the evidence bases provided in the BCF technical toolkit which has predominantly been used to sense check our plan.

For example, our priority areas and interventions map onto the review of case study evidence in the toolkit, shown below:

REVIEW OF CASE STUDY EVIDENCE

Intervention	Case study: Torbay	Greenwich	Tower Hamlets	Dementia	Midlands	Australia	Knappschaft	Valencia	ChenMed	Geisinger	CareMore	Kaiser	NYCC[1]
1 Self-empowerment and education		✓	✓	✓	✓	✓				✓		✓	✓
2 Multi-disciplinary teams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3 Care coordination	✓	✓	✓	✓			✓		✓	✓	✓	✓	✓
4 Individualised care plans	✓		✓	✓	✓	✓			✓	✓	✓		✓
5 Rapid response	✓	✓		✓						✓	✓		✓
6 Training for care professionals	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓
7 Co-location of services	✓	✓	✓					✓	✓	✓	✓	✓	
8 Shared electronic care records		✓					✓	✓	✓	✓	✓	✓	
9 Frequent primary-care appointments		✓			✓				✓		✓		
10 Risk stratification	✓		✓			✓			✓	✓	✓	✓	✓
11 Case management	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
12 Discharge support	✓	✓		✓							✓		✓
13 Service user registries	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
14 Scheduled service user follow-ups		✓	✓	✓	✓	✓			✓		✓		✓
15 Co-located pharmacies							✓	✓	✓		✓	✓	

1 New York Coordinated Care

SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

Inclusion criteria

- Strong, consistent published **evidence of efficacy**
- Also used in the overwhelming **majority of the 13 case studies looked at**

Intervention	*Number of reviews showing positive evidence*	*Additional insight from evidence base*	*Average impact[1]*
1. Self-empowerment and education	83% (20 of 24 reviews) assessed patient support for self-care and found a positive impact	Supported self-management has the strongest effect on clinical outcomes of all IC components when estimated at component-level *Tsai et al, Am J Manag Care, 2005 (August), 11(8), 478-88 (Table 4)*	Hospitalisations reduced by 25-30% (inter-quartile range)
2. Multi-disciplinary teams	81% (13 of 16 reviews) assessed MDTs and found a positive impact	All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalisation *Holland et al, Heart, 2005, 91, 899-906*	Hospitalisations reduced by 15-30% (inter-quartile range)
3. Care coordination	57% (8 of 13 reviews) assessed care coordination and found a positive impact	Interventions involving case management reduce HbA1c [in patients with diabetes] by 22% more than interventions without case management. *Shojana et al, JAMA, 2006, 296(4), 427-440*	Hospitalisations reduced by ~37% (pooled estimate only reported in 2 relevant reviews)
4. Individualised care plans[2]	64% (7 of 11) reviews) assessed care plans and found a positive impact	Personalised approaches using tailored information influence health behaviour more than uniform approaches *Graffy et al, Primary Health Care Research & Development, 2009, 10(3), 210-222*	Hospitalisations reduced by ~23% (pooled estimate only reported in 2 relevant reviews)

1 Impact measured from systematic reviews, including relevant interventions and containing meta-analyses of hospitalisation rate
2 Cochrane review of the evidence for personalised care planning (Coulter et al.) currently in process

SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

Given the correlation between the interventions outlined above and those contained within our BCF plan, reviewing the evidence has reinforced the approach and subsequent interventions outlined in this plan.

The case for change

Current estimates suggest that only 4% of the NHS budget is spent on preventative interventions but literature suggests that investing wisely and early into prevention could potentially lead to transformative change across Health and Wellbeing Board areas, (NHS Call to action, November 2013). We know that across the UK, health outcomes are poorer compared to our European neighbours (Law & Wald, 1999) and that we do not do enough to prevent long term disease and subsequent chronic disability. National evidence also suggests that we do not do enough to tackle the underlying risk factors associated with ill health, such as alcohol, smoking and obesity (NICE, 2014).

Prevention and effective management of conditions in the community is also likely to be more cost effective than waiting for patients to turn up sick at the doors of our GP surgeries or hospitals. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80% cost less than the £30,000 threshold used by NICE. And although some interventions take many years to pay-off, others do not - for example, effective management of atrial fibrillation or hypertension can show results within a couple of years. Smoking cessation programmes can have an impact over the short term when targeted on Chronic Obstructive Pulmonary Disease patients at risk of acute admission, (NHS call to action, Nov 2013).

Analysis of local data

As set out in the earlier sections of this plan, we know that citizens in Leicester City already suffer reduced life expectancy and more ill health than the national average. Moreover, analysis of specific diseases which are amenable to early intervention and preventative strategies shows equally adverse outcomes; therefore it is even more important for Leicester City to invest in the right interventions for these groups of patients, especially in light of the health inequalities seen across the City. The Marmot Review called for a strengthening in the role and impact of ill-health prevention, through

prevention and early detection of the key long term conditions related to health inequalities.

Many long term conditions are preventable and have common behavioural risk factors, amenable to public health intervention. Even when someone may have been identified as having one of these conditions there may still be opportunities, through appropriate health and social intervention, to prevent or delay the onset of complications and extend disability-free life. However, managing these conditions appropriately can be complex and challenging. The Better Care Fund programme provides major opportunity to improve services and their organisation locally, for the effective management of people with LTC.

Current epidemiology

In recent years, as part of the Quality and Outcome Framework (QOF), general practices collect information on patients with a number of common long term conditions. This is a useful local up-to-date source on disease prevalence:

Long-term condition	**Number** (xi)	**%**	**England (%)**
High blood pressure	43,233	11.4%	13.7%
Diabetes (17+)	24,554	8.3%	6.0%
Depression (18+)(xii)	17,253	6.1%	5.8%
Asthma	19,858	5.2%	6.0%
Chronic Kidney Disease (18+) (xii)	8,602	3.0%	4.3%
Coronary Heart Disease	10,022	2.6%	3.3%
COPD	5,145	1.4%	1.7%
Stroke/TIA	4,442	1.2%	1.7%
Cancer	4,171	1.1%	1.9%
Mental health	3,709	1.0%	0.8%
Atrial fibrillation	3,314	0.9%	1.5%
Heart failure	2,571	0.7%	0.7%
Learning disabilities (18+)	1,680	0.6%	0.5%
Dementia	1,745	0.5%	0.6%

Source: Health and Social Care Information Centre QMAS database - 2012/13

Many of these long term conditions are preventable and have common behavioural risk factors, amenable to intervention.

Modelled estimates derived from large health surveys, such as the Health Survey for England give a more complete estimate of the potential disease burden in Leicester, including people who are not aware of their condition or seeking medical help. These estimates show that whilst coverage of potential cases of diabetes, coronary heart disease and stroke are being relatively well identified, there is a need to focus attention on finding patients with COPD, high blood pressure, kidney disease or dementia who are not receiving routine care for their condition through primary care (see Table 7).

Long-term condition	Estimated total	Potentially Undiagnosed (%)
High blood pressure	63,524	32%
Diabetes (17+)	24,285	-1%
Chronic Kidney Disease (18+)	15,851	46%
Coronary Heart Disease	11,718	14%
COPD	9,077	43%
Stroke/TIA	4,782	7%
Dementia	2,677	35%

Table 7: Potentially undiagnosed LTC's across Leicester City
Source: Association of Public Health Observatories

Estimating the future long term condition disease burden

The local population over the age of 50 is estimated to increase by 10% (over 9,000) between 2013 and 2021. As a consequence the prevalence of long term conditions is also likely to rise in the future, in line with the general ageing of the population and reductions in mortality for a number of diseases. Among those aged 65 and above, it is estimated locally that half (51%) have at least one long term illness.

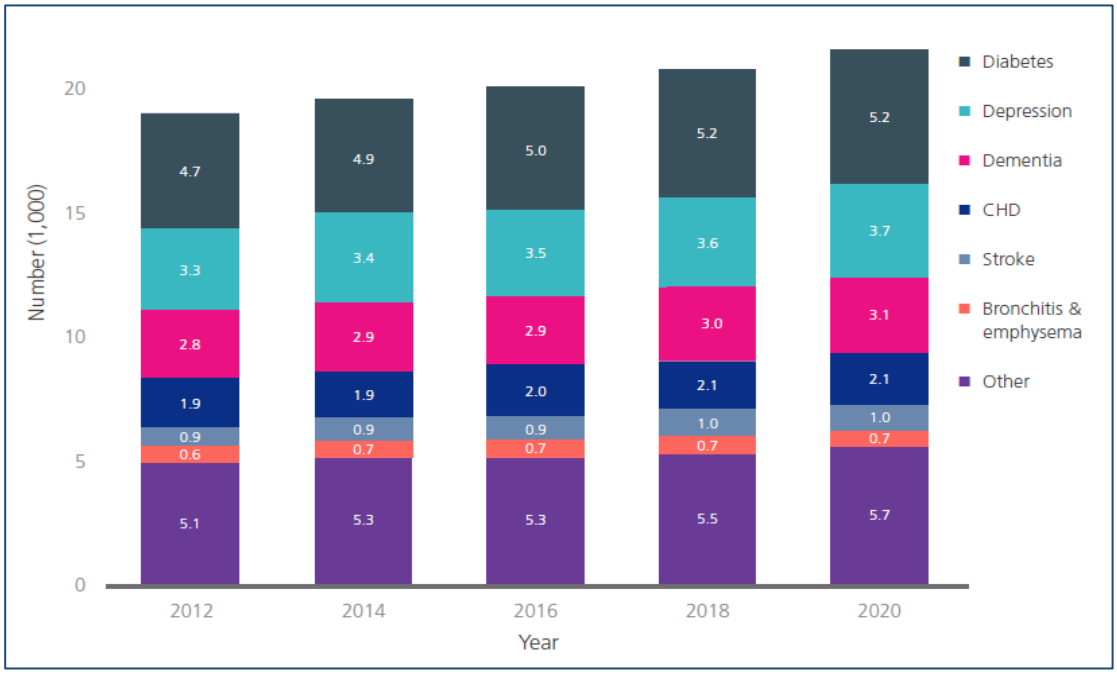


Figure 18: Estimated burden of long-term conditions in Leicester between 2012 and 2020 (ages 65 and above)

Emergency hospital admissions for long term conditions

When someone has a chronic condition they need to be able to manage it effectively and minimise situations that result in their avoidable admission to hospital. Over the last nine years there has been a significant reduction in the rate of such admissions in Leicester. In 2003/04 local admission rates resulted in more than 1,300 excess admissions, when compared to the national average in that year. By 2011/12 this fell to just 250 excess admissions, making the rate only slightly higher than the England average.

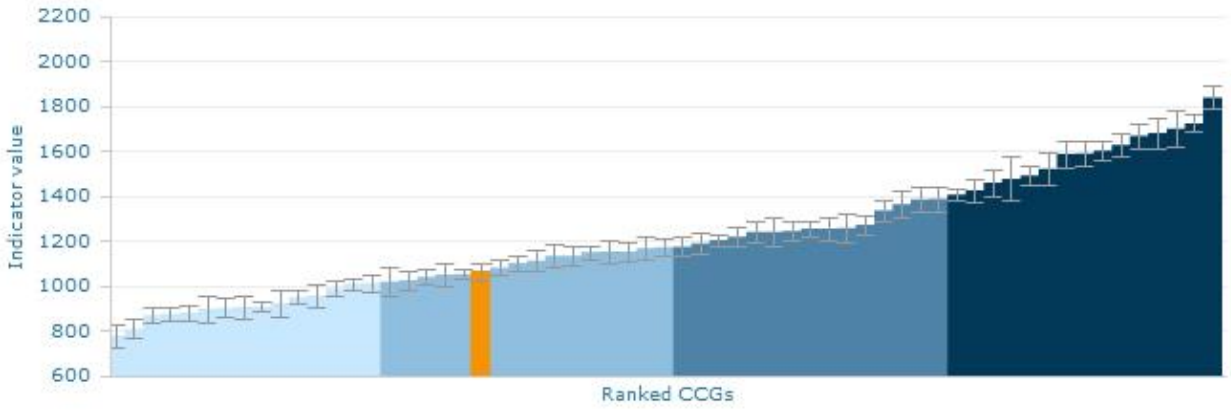


Figure 19: Emergency Admissions for conditions not normally requiring hospital admissions

Whilst this indicates an improvement in how well LTC are managed in the community but as Figure 19 shows, there is more that can be done in order to move to the top performing quartile nationally.

Health inequalities in the distribution of long term conditions

There are persisting inequalities in health of people with LTC in Leicester. In 2009-2011, emergency admissions for COPD were almost 5 times higher in the most deprived population of the city (standardised rate of 10 per 1,000 population) compared to the most affluent (2 per 1,000). The risk of a diabetes emergency admission is twice as high among the most disadvantaged population (16 per 1,000) when compared to their affluent counterparts (8 per 1,000).

Premature mortality due to cardiovascular and respiratory conditions is twice as high in the most disadvantaged population of the city (116 per 100,000 vs. 53 per 100,000 and 54 per 100,000 vs. 19 per 100,000, respectively), as is the risk of death due to diabetes (70 per 100,000 compared to 37 per 100,000).

Financial case for change

Finally, evidence that both primary and secondary prevention can impact positively on financial spend across a health economy can be found, with Wanless (2002) suggesting that £30b could be saved across healthcare spend if the public were fully engaged in preventative activities and Heckman (2006) estimating that the annual expected rate of return for preventative interventions to be between 6-10%. However despite this, investment in preventative services remains lows nationally and indeed, locally.

However, Leicester City is committed to changing this and this is evidenced both in this plan and the strategies on which this plan is aligned, including the HWB strategy, the Five Year Strategic Plan and the CCG Two Year Operating Plan.

References

As well as the evidence used in the national BCF toolkit, we have used a range evidences bases, drawing on both nationally produced documents, to journal articles and local evidence from our within our health and social care economy. These are provided in Appendix 3: Evidence base.

The case for change

Improving urgent and emergency care is a key priority for the CCG, and aligns both strategically and operationally with this priority of 'reducing time spent avoidably in hospital'. Historically the model of care in Leicester City has been acute-centric, with over-reliance on hospital services and subsequently less early management of disease within community and primary care.

Our rationale for changing the way urgent care is delivered across the city is based on five challenges:

1. We are experiencing difficulty achieving national standards, for example we need to make sure we deliver to our four hour targets.
2. Existing urgent care settings are crowded and uncomfortable – citizens tell us that we need to improve the urgent care environment.
3. Navigating the urgent care system is complex and different depending on where you live in LLR, for example alternatives to A&E can be confusing with different models in place between different urgent care and minor injuries units. Patients and their families need to know where is it best for them to go when they are ill.
4. Urgent care services are not well connected to community health services – we need to deliver joined up services so, for example the ambulance service is aware of elderly frail patients being case managed by community staff.
5. We need to deliver on the national ambition to reduce emergency admissions to hospital.

We aim to fulfil the challenge set in *Everyone Counts* of a reduction of 15% in hospital emergency activity through the plans set out in the CCG Operating Plan 2014-16 and the wider Five Year LLR Strategic Plan but the size of this reduction against a context in which NHS Leicester City CCG and its legacy commissioners have held emergency admissions at or below 2008/9 outturn will be a significant challenge.

Our BCF plans are central to this transformative change, designed to keep people out of hospital where clinically appropriate and if they do require hospitalisation, to facilitate an efficient discharge process to ensure that time in hospital is reduced.

Looking at the outcome measure of 'reducing time spent avoidably in hospital' for those patients with chronic long-term conditions, when compared to the 10 similar CCGs in the 'Commissioning for Value' data set tells us that we perform better than most of our peer cohort:

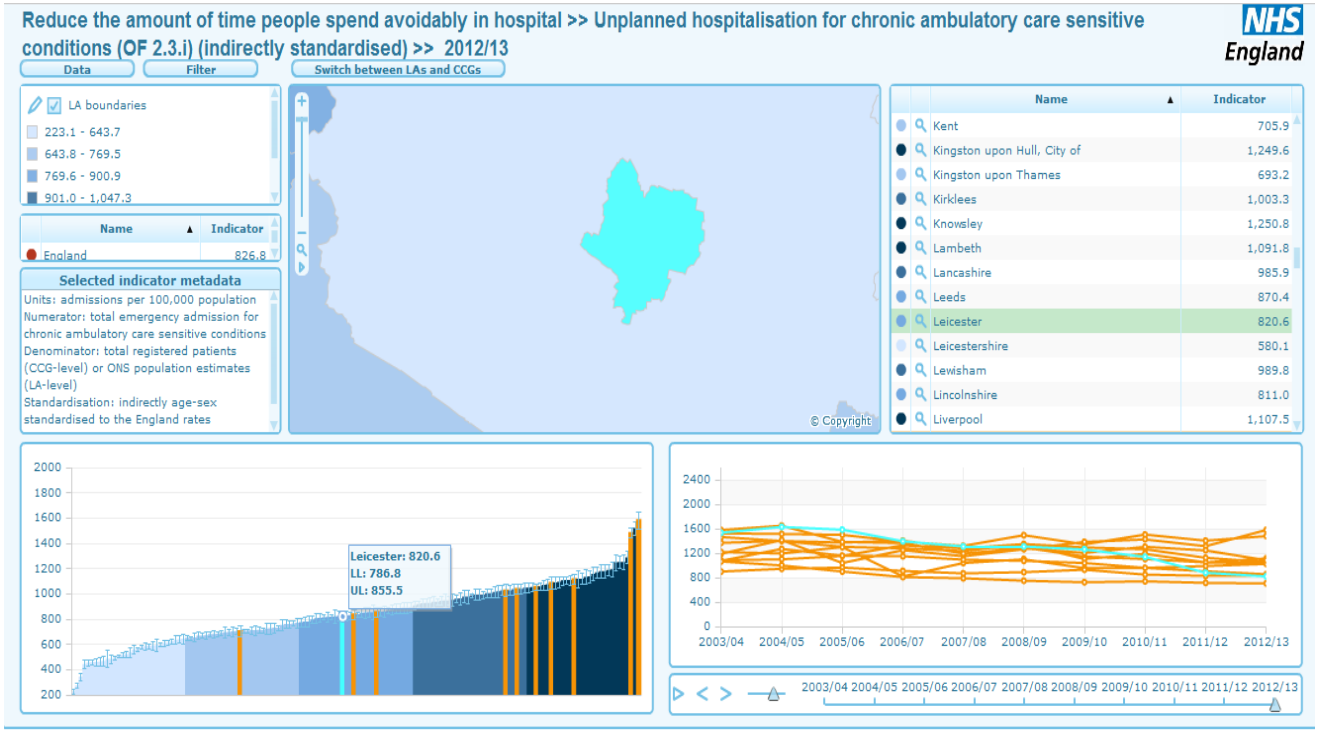


Figure 20: The NHS Levels of Ambition Atlas: Reducing the time spent avoidably in hospital. Comparison of Leicester City CCG vs. nine similar CCGs in the country

However, when compared to our neighbouring Health and Wellbeing Boards Areas and CCG's across LLR, the atlas tells us some of the reasons underlying the life expectancy gap between the city and the county, many of which have been discussed in earlier sections of this plan.

The Commissioning for Value data pack provides high-level data on elective and non-elective service areas to support effective commissioning for value. It identifies opportunities for CCGs to improve outcomes and increase value for local populations. The data compares Leicester City CCG to other CCGs of a similar population context and outlines areas where the greatest improvement could be made.

The data for Leicester City, shown in figure 21 below, clearly demonstrates that scale of opportunity in various key disease areas is substantial. These specific disease areas are targeted through the interventions described in this section, with priority placed on circulatory and respiratory diseases.

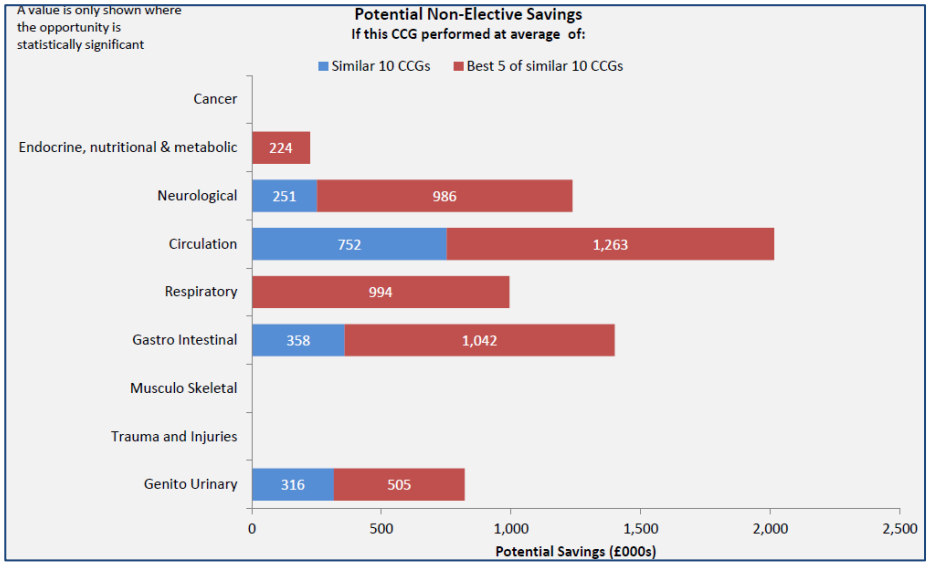


Figure 21: Potential areas of non-elective savings for Leicester City CCG produced by C4V, (2013)

System wide analysis has also provided commissioners with evidence that not enough is being done within primary and community services to keep patients out of hospital; and local analysis of ambulance data shows that once a 60+ year old Leicester City patient reaches the acute site, there is almost 67% chance of admission, regardless of the reason for attendance.

Repeated reviews of the urgent care pathway in Leicester have all concluded that patients are often admitted, particularly older patients, because there is either no service available at that specific time/day or that the admitting clinician did not know of any other service available (ECIST review, 2010, 2011) and this leads to almost 20% of all emergency admissions via ED being potentially avoidable (Utilisation Review, EMPACT, 2011). The same conclusions are drawn when reviewing the discharge pathways and DTOC data for the City – either community step down services were lacking or clinicians were not aware of what was (Utilisation Review, EMPACT, 2012).

In 2013/14, the CCG trialled a 'GP in a Car' service, designed to divert potential admission to community settings. This was successful in avoiding both ED attendance and admission and we have therefore commissioned a larger scale service, the Clinical Response Team, as the first response when an eligible patient calls 999 in crisis.

The CCG and Local authority have worked together over a number of years to test out what works for our population. We know that patients trust their GPs and therefore targeted, individualised care planning & coordination is essential, (Kings Fund, 2011). However, evidence also tells us that a team approach is vital to the successful management of complex patients (Graffy, Grande & Campbell, 2008) and therefore we have commissioned one joint Health and Social Care Unscheduled Care Team, co-designed between commissioners and providers across health and social care services to work with general practice and the Clinical Response Team to make best use of integrated community services with a two hour response time.

Finally, in response to the discharge pathway reviews and the increasing number of DTOCs noted in the system, 30 virtual beds will be commissioned to provide care in the

patient's own home. Again, this is based both ECIST & Utilisation Review recommendations (2010 & 2011) and on local analysis of a pilot site in a neighbouring CCG area, where Delayed Transfers of Care have been minimised as a result.

Our interventions, described fully below, are designed to stop both of these happening at both inflow and outflow points, thus reducing the time spent avoidably in hospital.

References

As well as the evidence used in the national BCF toolkit, we have used a range evidences bases, drawing on both nationally produced documents, to journal articles and local evidence from our within our health and social care economy. These are provided in Appendix 3: Evidence base.

The case for change

The final element of our plan enables a holistic approach to enabling independence for our BCF cohort.

The key to delivery of this sits with our Planned Care Team, described fully below, which delivers a more integrated community response to providing health and social care services and is centred around the individual patient and their needs as per our core vision for integrated care.

This element of the pathway will improve the quality and patient experience of care. It will ensure that patients receive a holistic assessment of their health and social care needs at an early stage rather than simply a restricted single track focus on addressing a presenting complaint without trying to address the underlying issues causing the problem. We know that many older people experience care that is fragmented between health and social care components which do not communicate well with one another and which address single problems rather than looking at the complete interaction between health and social care factors. This MDT model of care has been shown to benefit patients in a variety of pilots; a meta-analysis of published academic articles on integrated care showed that such schemes delivered an overall reduction in hospitalisation of 19%, (McKinsey, 2013). Equally, case management and care coordination of this type have also been evidenced, with models such as those in Croydon, Torbay & Tower Hamlets showing a positive impact on care, (McKinsey, 2013)

The inclusion of a mental health component to this integrated service allows us to address the often critical but under recognised psychological and psychiatric components of morbidity, in older people especially, which can have an adverse impact on ability to self-manage long term conditions especially when combined with issues of social deprivation as is the case with significant sections of the Leicester City population. Putting this resource within the planned care team will promote the parity of esteem agenda and offer patients and staff resources at an early stage to establish diagnoses and provide support to avoid crises.

We know that frailer older people are often taken to hospital with problems which do not require acute care management (see for example Tan et al. "Emergency Hospital Admissions for ambulatory Care Sensitive Conditions: Identifying the Potential for Reductions" King's Fund 2012"). We know that while acute hospital services can be essential and life saving for some older people, all too often an acute hospital spell can lead to subsequent hospital induced problems such as infections, delirium, falls, loss of confidence and loss of independence. Providing the right resources in the community will enable older people to be appropriately managed in their own homes or close to home where the experience of care will be better and the return to independence accelerated.

Those with complex mixture of health and social care needs and especially those who are older often find that care is fragmented. This planned care service will ensure that the most vulnerable and highest risk older patients have a seamless experience of care between health (including mental health) and social care.

Greater integration between the neighbourhood community nursing teams and their social care locality-based colleagues ought to improve communication and cooperation around key issues of safety such as safeguarding, prevention of potential harm from falls due to environmental or care requirement issues e.g. continence, nutritional concerns or medicines safety concerns.

Mental health services

Improving mental health service outcomes are a priority for both the CCG and local authority and a LLR Better Care Together priority. In particular the plans are to increase resilience in the population, earlier and more effective intervention, integrated local care delivery and proactive timely response to crisis and to managed demand for secondary care services.

A recent independent review of the LLR mental health pathway has evidenced that it is under significant pressure, with increasing delayed transfers of care, increasing length of stay, and people placed in out of county acute placements due to lack of local provision.

Benchmarking indicates bed capacity is within range of peer services but that community options are less developed leading to a higher LOS. Analysis shows:

1. In 2013/14 out of county (OOC) placements increased significantly. LLR spend on OOC placements in 2013/14 was £4m, with Leicester City CCG contribution of £1.9m towards this.

2. The average weekly cost of OOC placement was £3,600 per week, significantly higher than local provision.
3. City MH/LD DTOC has been increasing during 2013/14. It has been consistently higher per weighted population than county HWB areas, on average 4.5 higher per 100,000 population.

Based on this evidence, the health and social care system is jointly embarking on an improvement programme for mental health in line with the principles outlined in Service Transformation; lessons from Mental Health (Kings Fund, 2014); the interventions described in this plan are simply the first steps towards realisation of the whole vision for mental health services in the city.

References

As well as the evidence used in the national BCF toolkit, we have used a range evidences bases, drawing on both nationally produced documents, to journal articles and local evidence from our within our health and social care economy. These are provided in Appendix 3: Evidence base.

Step 3: Using the evidence base to design of the Leicester City BCF

Leicester City CCG and the Leicester City Council have been working with our citizens, clinicians, practitioners and partner organisations to define and prioritise the interventions required to transform our pre and post hospital pathways. This has been a process conducted since November 2013 and achieved through multi-agency workshops, each with a specific aim.

Workshop	Attendees	Objective
Workshop 1: Population segmentation (November 14th 2013)	Core BCF planning group	• To identify the population on which to focus the BCF
Workshop 2: NHS call to action (December 3rd 2013)	CCG GPs, LA representatives, patients & public, stakeholders	• To gain views from citizens on what the BCF should focus on and how it could be delivered
Workshop 3: Integrated Care pathway design (December 17th 2013)	Core BCF planning group	• To assess the evidence base for IC models nationally and internationally • To assess local analysis of acute care usage • To co-design a high level model of intergaretd care
Workshop 4: Specific focus – Pre-hospital pathway I	Core BCF planning group	• To assess the evidence base for admission avoidance interventions nationally and internationally

(December 31st 2013)		• To assess local analysis of acute care usage • To co-design a series of integrated services to keep people away from the acute site where appropriate
Workshop 5: Specific focus – Pre-hospital pathway II **(January 7th 2014)**		
Workshop 6: Discharge planning & maintaining independence **(February 5th 2014)**	Core BCF planning group	• To assess the evidence base for reducing occupied bed days nationally and internationally • To assess local analysis of acute care usage/DTOC reports • To co-design a series of integrated services to enable efficient discharge and independence at home
Workshop 7: Alignment of the pathway with the VCS across the City **(March 11th 2014)**	CCG & LA representation 30+ VCS organisations	• To understand from the VCS how the services they provide would complement the BCF pathway

Following the workshops, project managers from the Better Care Fund Team across organisations formed teams for each project and followed the Leicester City CCG commissioning process, including a financial impact assessment, a quality impact assessment, an equality impact assessment and a privacy impact assessment. This process culminated in the production of detailed business cases for each of the priority schemes which were then presented to the Joint Integrated Commissioning Board for approval on behalf of the Health and Wellbeing Board. Concurrently, all schemes were subject to the CCG and LA governance procedures to ensure robust critique of the proposed pathway as well as to secure strategic support for the programme.

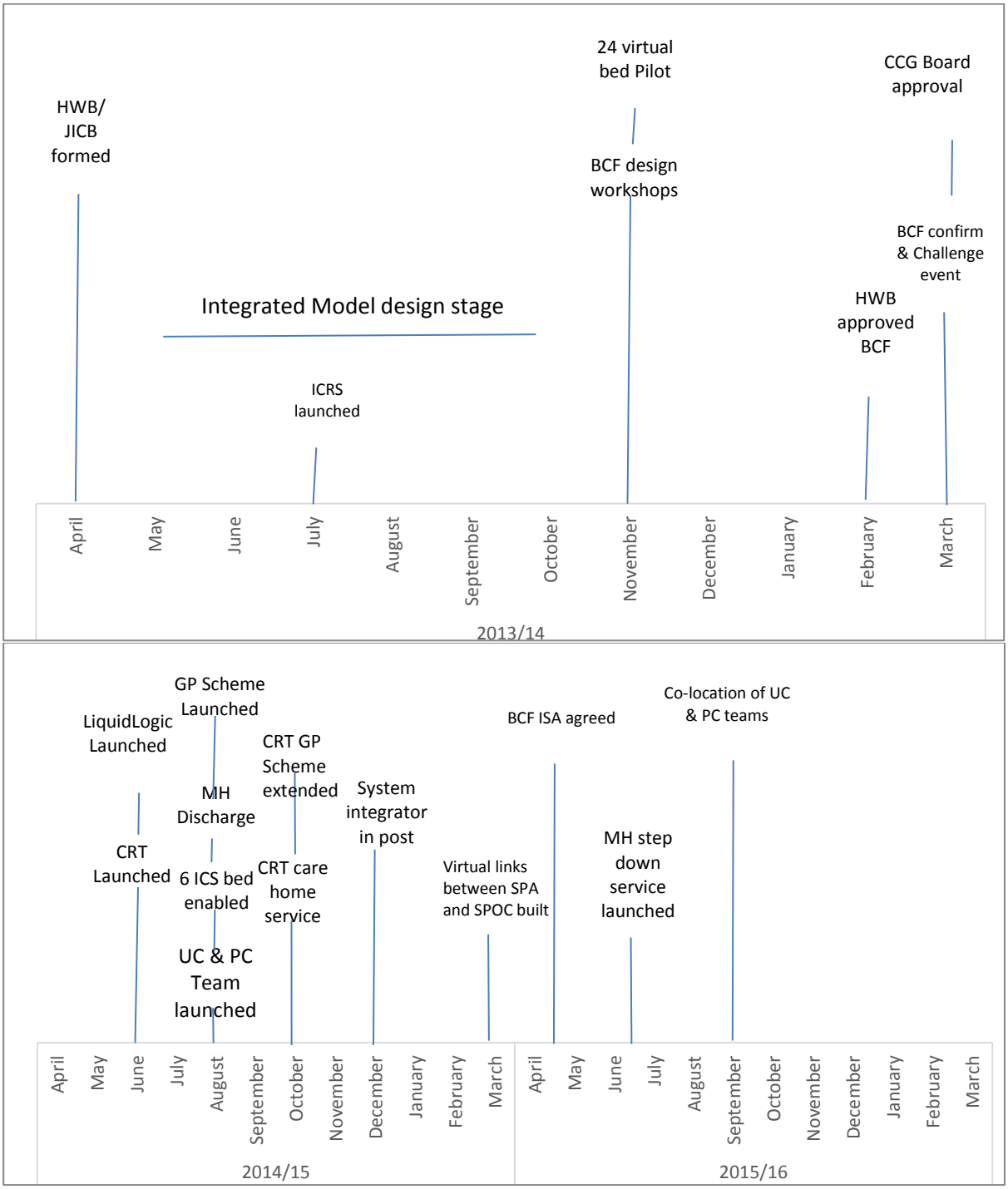
This also ensured alignment with other related programmes of ongoing work, such as the LLR Five Year Strategic Plan and specific pieces of work through, for example, the Urgent Care Working Group.

A final 'confirm and challenge' workshop took place on February 25th 2014 to ensure that all partners were in support of the proposals prior to mobilisation and to ensure that all partners across the BCF team were in agreement to the financial allocations in an open and transparent manner. Priority schemes for mobilisation were selected based on the impact modelled in terms of quality, cost and activity, outlined in later sections of this plan.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The key milestones associated with delivery of our vision extend back to 2013/14 and forward to 2015/16. A full mobilisation plan is attached as Appendix 4.



Key interdependencies are as follows:

- the LLR Five Year Plan and Delivery Programme;
- Government policy in relation to integrated health and care, pooled budgets and the future arrangements for the better care fund;
- the implications of operating in a challenged health economy;
- the roll out of 7 day services, in primary care and other settings;
- adoption of the NHS Number;
- development of the Single Point of Access;
- revised information sharing agreements for LLR;
- recruitment to a number of new services, and extended services and training programmes associated with new ways of working;
- ongoing evaluation of schemes against the metrics and financial benefits within the plan, supported by improved KPIs and data quality by scheme;
- implementation of user experience metrics within individual schemes, as well as by using the nationally prescribed metrics;
- implementation plans associated with the Care Act;
- any future configuration changes to the NHS in particular commissioning bodies.

Please articulate the overarching governance arrangements for integrated care locally

The Programme Structure

The governance of the Better Care Fund Programme builds on a mix of strong existing partnership groups and a new Better Care Fund Implementation Group.

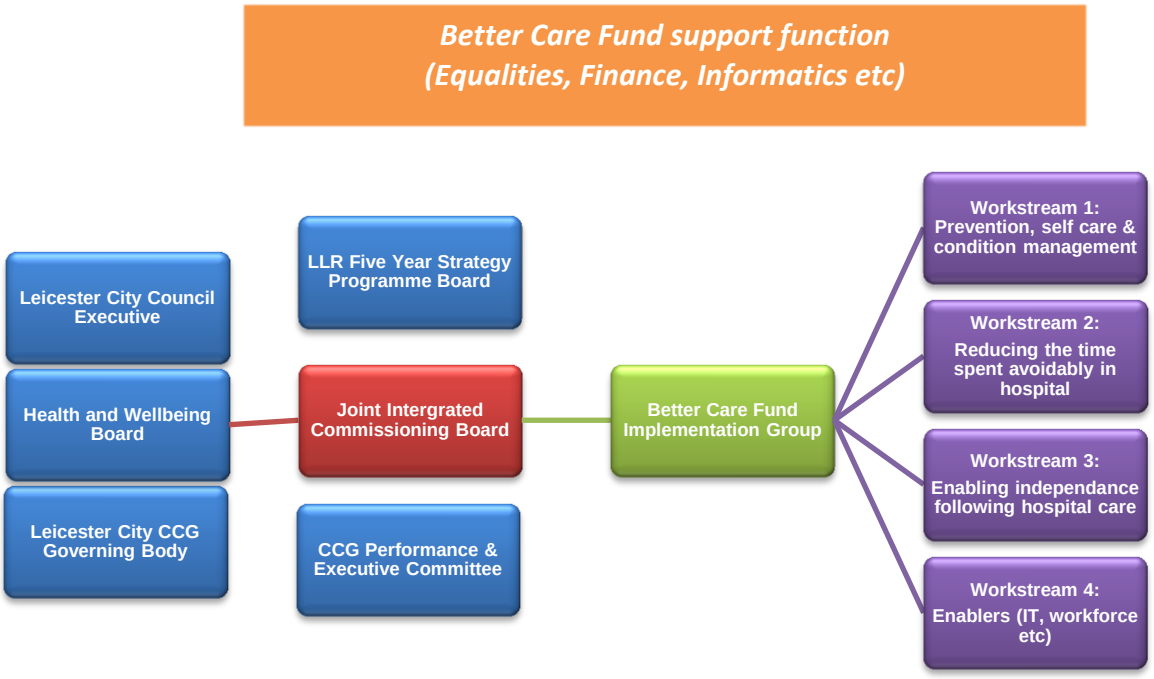


Figure 4: Better Care Fund programme structure

Governance arrangements: strategic oversight

Our journey towards integrated care began in 2013/14 following the introduction of the Health and Social Care Act 2012. Prior to this, the Leicester City HWB had been running in shadow form with joint commissioning arrangements in place between the PCT and the Local Authority through a shadow Joint Integrated Commissioning Board.

In April 2013, both the Leicester City Health and Wellbeing Board and the Joint Integrated Commissioning Board were formally established. The JICB held responsibility for delivery of the HWB strategy as well as overseeing joint commissioning between Leicester Clinical Commissioning Group and Leicester City Council.

The JICB consists of executive leaders from the health and social care economy, including the Managing Director of Leicester City CCG, the Chief Operating Officer of the Local Authority, the Director of Adult Social Care, Directors of Finance for the CCG and the local authority as well as clinicians from both the CCG and partner organisations. The Terms of reference for this Board are attached as Appendix 5.

Following a series of joint strategic meetings between partners across the Leicester City health and social care economy in September and October 2013, it was decided that the JICB should formally take over the strategic management of the Leicester City Better Care Fund, reporting progress directly to the HWB.

Given the collaborative nature of this programme, regular progress reports will also be provided to the LLR Five Year Strategy Programme Board to ensure alignment with the overall strategic direction of travel of the LLR health and social care economy.

Governance arrangements: Delivery

The delivery of each work stream of the BCF is overseen by the Better Care Fund Implementation Group, which began meeting in January 2014. This runs bi-weekly and is chaired by an independent lay member of the CCG. Terms of Reference are attached as Appendix 6.

The Implementation Group is attended by the following stakeholders:

- the four Chairs of the general practice localities in the CCG;
- Director of Adult Social Care, Local Authority;
- Head of Strategy & Planning, CCG;
- Lead Nurse, CCG;
- Heads of Service at the Local Authority;
- Head of Strategic Change, UHL;
- Heads of Service at LPT;
- Heads of Service at SSAFA;
- Heads of Service at EMAS;
- Workstream Project Managers across organisations.

Relevant functions across the organisations attend for specific items as required.

Each project completes a highlight report, outlining expected and actual progress, key risks and quality issues and actions for the coming fortnight. Any remedial actions are agreed and monitored here, with unresolved issues being escalated to the JICB Chair within 1 working day.

Sub-groups of the BCF Implementation groups, detailed below, are predominantly chaired by Governing Body GPs where relevant; where not, they are chaired by senior officers across health and social care.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Performance management of the programme

As the BCF is one of the key enablers to multiple streams of work across the CCG, Local Authority and provider organisations, a comprehensive suite of monitoring has been formulated using the practical outcomes selector (NWL toolkit), based on the Quality/Experience/Cost framework outlined in the BCF technical toolkit. These outcome measures have been agreed at the BCF Implementation Group, with input from all partner commissioner and provider organisations across the Health and social care economy and align to HWB strategy, the JSNA and the two and five year CCG plans.

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level. These have been drawn from the ASC, NHS and public health outcomes frameworks as well as local flow measures and enables all health and social care organisations to understand the quality of services and the patient flow through the system in terms of inflow, throughout and outflow metrics, with the same dashboard serving the Urgent Care Working Group.

Monitoring at this level has enabled the JICB and the CCG Performance Exec to understand issues affecting performance and intervene early to mitigate more strategic issues. For example, monitoring at this level has enabled early identification of issues affecting delayed transfers of care within mental health units and has accelerated multi-organisational change to improve patient experience and performance.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme. This shows a suite of local metrics by project, providing a coordinated view which aids understanding of any barriers to achievement of the overarching national metrics, as well as providing further commissioning intelligence across the Leicester City health and social care system.

Again, monitoring at this operational level has already led to change in pathways. For example, monitoring of the Clinical Response Team activity outlined capacity in the service to take on a wider range of calls from EMAS early on in the project. As a result, call categories were increased, leading to a greater number of calls being diverted to the CRT within a few weeks.

Practice level – Weekly reporting

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

Assuring delivery

a. Pay per performance/risk pool

Following the publication of the revised BCF guidance in July 2014, the impact of the requirement to achieve a 3.5% reduction in emergency admissions was risk assessed, both for the Leicester City BCF plan and as a whole across our the 3 LLR BCF areas.

A reduction of 3.5% equates to 1013 emergency admissions which represents £1.5m of the BCF pooled budget, based on the average cost of an emergency admission of

£1490. This is the proportion of the Leicester City pooled budget fund which will now be subject to pay for performance. The Leicester City BCF plan submitted in April 2014 did not identify a contingency for the risk pool. However, agreement between the CCG, Local Authority (and partner providers, including the Acute Trust) has been reached to hold £1.5m as a contingency fund in 2015/16.

In order to assure delivery against this metric in particular, contributory trajectories for each intervention have been agreed at the BCF implementation Group and these will be monitored bi-weekly.

b. Interdependencies

It is recognised that other factors outside of the BCF interventions and related HRG codes will have an impact on the total emergency admissions performance, given the definition of this metrics. For example, in Q4 2013/14, Leicester City CCG saw its emergency admissions increase by c20% without any corresponding increase in either ED attendance or decrease in community activity. Investigation shows that this is largely due to a change in coding practice as a result of pathway changes in the urgent care system. This increase is currently under review with UHL. The intention within the Leicester City BCF plan is to be clear about the relative contribution of the interventions mobilised and be able to record and demonstrate their impact.

4d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
Priority 1: Prevention, early detection and improvement of health-related quality of life	
BCF 1	Risk stratification
BCF 2	Lifestyle Hub
BCF 3	General practice scheme (2.1-10%)
Priority 2: Reducing the time spent in hospital avoidably	
BCF 4	Clinical Response Team
BCF 5	Unscheduled Care Team
BCF 6	System coordinator
BCF 7	Intensive Community Support Service
BCF 8	IT integration
Priority 3: Enabling independence following hospital care	
BCF 9	Planned Care Team
BCF 10	Mental Health Discharge Team
BCF 11	Integrated Mental Health Step Down Service

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

Our BCF programme has a number of projects, each of which has a lead project manager to coordinate risks pertaining to that project. A standard template is utilised to capture any risks which follows the CCG risk management strategy outlined below and uses a consistent impact likelihood scale, outlines mitigating actions and the and areas of action and responsibility. These individual project risks can then be brought to the attention of the BCF programmes Implementation Group to aid in a coordinated oversight and management of any risks (clinical and non-clinical) to the programme. Individual organisations are then able to escalate through their organisations as appropriate utilising their existing processes and back down to the BCF Implementation Group as appropriate.

BCF Risk management strategy

The CCG has in place a Risk Management Strategy and Policy that clearly defines the principles, systems and mechanisms in place to manage risk within the organisation. It is embedded in the normal management processes and structures of the CCG and as such is the framework used to manage all risks regarding the Leicester City Better Care Fund.

The Risk Management Strategy and Policy requires all risk management to be systematic, robust and evident, and that risk management processes are applied to business planning at all levels. It provides guidance to staff in managing risk appropriate to their areas of responsibility. The strategy clearly sets out the authority levels and accountability arrangements and identifies key individuals within the organisation who have specific duties with regard to the management of risk.

The strategy and policy clearly describes the processes that the CCG has put into place in order to adequately manage risk. This includes supporting employees to identify, assess, report, treat, control and monitor risks through robust management of directorate risk registers, with the most significant risks being escalated to the Board Assurance Framework.

The CCG has adopted a robust risk assessment and identification process that captures both internal and external sources of risk using proactive and reactive methods. These are detailed below:

- Top down – proactive identification of risks that directly affect the CCG's achievement of its strategic objectives. This includes the consideration of political, economic, social, technological environment and horizon scanning to identify emerging opportunities and threats;

- Bottom up – assessment through the use of Directorate Risk Registers, claims and litigation, trends in incidents, trends in complaints and through performance management mechanisms, for example the CCG's performance dashboard.

Risks are categorised into one of four groupings – clinical, organisational, financial and information. The CCG has adopted the Australia/New Zealand (AS/NZ Standard 4360 1999: Revised Ed. 2004) as this provides a generic model for identifying, prioritising and dealing with risks in any situation. Risk is assessed using the 5 x 5 model, which considers the risk in terms of it resulting in injury/safety, legal or financial threat, performance or service interruption, regulatory action, or adverse publicity and damage to the reputation of the CCG or wider NHS.

Each risk is assigned to an appropriate register (either corporate or directorate) depending on the score for its impact multiplied by the score for the likelihood of that occurring. Each rating is presented as a mitigated score based upon consideration of the controls in place. Once graded they fall into four categories; low, moderate, high and extreme risk. Actions to further reduce the risk rating are recommended. Controls for individual risks are only recorded where they have been verified as making an active difference to reducing or mitigating a risk.

Risks are reviewed by the Chief Corporate Affairs Officer, Head of Corporate Governance or by the Senior Management Team for corporate risks, or by the designated lead for departmental risk registers with guidance and support from the Chief Corporate Affairs Officer.

The full risk log is attached as Appendix 8.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place between commissioners across health and social care

In terms of the changes enacted to BCF policy in July 2014, (ref the implications of the new pay for performance scheme, new metric definitions and baselines provided as part of the resubmission process) a contingency fund has been created given the greater risk to achievement of the emergency admissions target in order to mitigate the proportion of the fund that is subject to pay for performance - £1,560m – in full. This was agreed in August 2014 by a CCG/LA risk workshop and ratified by the Joint Integrated Commissioning Board. This is due to the challenged health economy context and the current gap between performance and the 3.5% threshold needed to achieve.

It is recognised that the pay for performance scheme will operate quarterly in arrears and if the trajectory is not being achieved monies from the risk pool within the pooled budget are released to CCGs so that corresponding activity in the acute sector can be reimbursed. This will be monitored at the BCF Implementation Group, with any deviation from trajectory and recommended actions reported to the JICB chair within 1 working day for resolution.

£1,560m will be held in reserve in the pooled budget and not applied to other expenditure in the BCF in 2015/16 until assurance can be achieved on delivery of the target (at least six months performance information will be required in the first instance).

Depending on the future BCF policy framework beyond 2015/16, a proportion of the reserve may need to be carried forward to provide a contingency on a recurrent basis. It is hoped this would however be a much smaller figure if the BCF plan is performing overall.

Financial principles have been developed for 14/15 outlining the arrangements in place between the CCG and the Local Authority, and a full Section 75 agreement is in production.

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place between providers and commissioners

In the event that target reductions in emergency admissions are not achieved, the contingency will be used to fund the additional activity within the acute sector.

The application of the monies from the risk pool arising from non-performance against the 1013 reduction in emergency admissions will be actioned via the existing contractual routes between the CCGs and University Hospitals Leicester.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Our BCF plan fully aligns to wider changes within Adult Social Care at Leicester City Council. This includes:

- Care Act implementation programme;
- strategic commissioning reviews for independent and voluntary sector provision (to meet both statutory and preventative needs);
- housing and estates programme;
- ICT strategy;
- capital programme;
- departmental revenue strategy.

Other key interdependencies

As referenced in Section 4, there are a range of interdependencies which will impact on the success of this programme. Where possible, these plans have been aligned with resource/plans either shared across programmes or enveloped by the BCF.

For example, a key determinant of being a challenged health economy has been over reliance on an acute bed based model of care. By aligning the interventions in this plan to the acute provider plans to reduce bed stock over the next 5 years, the BCF has become a key enabler of success across these 2 different but aligned programmes of work.

Duplication of effort in inter-dependant workstreams has also been eliminated. For example, much of the IM&T requirements detailed in this plan (Information governance relating to risk stratification and development of the use of the NHS number) has been done at a sub-regional level in line with the LLR IM&T board, a function of the LLR Five Year Strategy in order to reduce duplication and maximise efficiency.

Communication between initiatives

As referred to earlier, the BCF Implementation Group and the Joint Integrated Commissioning Group both report into various CCG and system-wide groups. This dual reporting (for example, activity and finance associated with the BCF is monitored at both the JICB and the CCG performance exec) facilitates alignment to other related plans, such as System Resilience Groups and the Five Year Strategic Planning function. This communication is the responsibility of all those who attend the BCF Implementation Group and the JICB, with communication to other groups specifically written into the TOR to assure alignment.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and five year strategic plans, as well as local government planning documents

Alignment with CCG 2 Year Operational Plan and the LLR Five Year Strategic Plan

Schemes described in this plan are all included as part of both the Leicester City CCG Two Year Operational Plan and the five year strategy and is the key driver to achieving transformative change within both the Leicester City and wider Health and Social Care economy over the next five years. Our core priorities are coordinated with our partner Health and Wellbeing Board areas across Leicestershire County and Rutland County, taking into account the differences in need, demography and geography through differing delivery methods.

The changes presented in this plan will form the first 2 years of an overarching move towards a new way of working in recognition of the significant capacity and demand issues faced within the local health and social care economy. All BCF schemes listed in this plan have therefore been factored into both strategic and financial planning for 2014/15 and 2015/16, and have been contracted with providers for 2014/15.

Through the Five Year Strategic Plan, alignment with Provider Cost Improvement Plans has also been achieved, with the impact of the BCF taken into account in Provider assumptions.

Evaluations of the interventions in this plan will be conducted through 15/16 to ensure that those which will need to be included from 2016-18 can be commissioned as part of the core planning processes.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

CCG status
The CCG believes that co-commissioning of primary medical care represents an intrinsic element in realising our long-term ambitions for health and health services in the city, supporting the delivery of a broader range of services in primary and community settings and reducing over-reliance on acute services – in direct alignment with the direction of the Leicester City BCF. To do this will require radical transformation of current primary care services and the way in which they are now provided. To this end, the CCG has expressed an interest to take on the full scope of primary care commissioning responsibilities.

Engagement of primary care providers
The interventions described in this plan were co-designed with our Governing Body GPs and our member practices and designed to complement the enhanced services recommended in Transforming Primary Care.

Our Governing Body GPs have been engaged from the outset, directly co-developing the interventions in this plan. Member practices have been engaged monthly at both a locality level and at Protected Learning Time events since December 2014, through face to face briefings and workshops to ascertain:

1. How practices can support delivery of the aims of the Leicester City BCF and;
2. How the BCF interventions can help support practices during a time of sustained high demand

These events raised a wide range of issues, each of which has been directly resolved where possible and fed back at future meetings.

For example:

Issue raised:	By who:	Result:
Capacity in primary care continues to be an issue	Member practice	Locality based schemes have been developed to increase the capacity in primary care to support the BCF cohort
The system will not be truly integrated until health professionals have a single number to call for health and social care	Governing Body GP	This has been built into plans for the joint health and social care teams for 15/16
Governing Body GPs do not have capacity to run individual sub groups of the BCF	Governing Body GP	Added to risk register, with teleconference facilities secured for all meetings

The interventions designed have been approved by the CCG Governing Body on behalf of member practices, with the resultant model of care presented to city-wide Protected Learning Time events through 2014/15.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a. Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting social care services in the Leicester means:

- Helping to ensure that those people with eligible needs within our city continue to receive the support they require, in a time of growing demand and budgetary pressures.
- Delivering new approaches to joined up care, which help people to remain healthy and independent.

Eligibility is currently set at substantial and critical, and assumes that this will continue unchanged as the national eligibility threshold is introduced with the Care Act in April 2015.

Leicester does not operate individual service criteria for statutory services, this being based on eligibility for funded care, not a service type; however we expect to maintain the same levels of access to statutory services as now.

By ensuring proactive interventions to our target population, to support prevention, self-care and to enable people to tackle the wider determinants of poor health and poor quality of life.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Funding currently allocated via the BCF to the Council has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and commissioned services to eligible clients. This has also supported the provision of advice, signposting and a range of preventative services to the wider population.

Sustained funding from the Better Care Fund is required to maintain this position, and additional resources will need to be invested in social care to deliver the rapid access services that are required to respond to our agenda to reduce unplanned admissions and admissions to care homes.

A process has been completed which has identified a recommended level of support for social care that both requires Leicester City Council to ensure that it is delivering services in the most cost efficient manner and allows for a protection fund in 2015/16, with an

investment pool equal to the expansion of services needed to meet the required reduction in use of the acute sector. This is achieved through the schemes in relation to investment in crisis services within the unscheduled care team; investment in social work capacity to move towards extended / 7 day services; investments in assistive technology and practical help at home to support additional demands from proactive care models.

The schemes across unscheduled and planned care will contribute to the ongoing protection of social care services, by reducing and delaying the need for statutory services, as well as preventing admissions to long term care through effective crisis intervention and hospital admission avoidance. By investing in preventative services such as technology, this will also reduce the burden on health services, for example in reducing falls and managing medications compliance.

Demographic pressures are well understood and national tools used to forecast their financial impact. Demographic pressures were a part of the discussions on estimating the costs of protecting adult social care although the BCF will not in itself mitigate these pressures in full; the council is separately preparing its budget proposals which recognise the costs of demographic growth.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

A total of £5.65m has been allocated to protect social care, in addition to investment funding to deliver the out of hospital services required in the community as part of the BCF plan.

This includes the £840k that has been allocated to support the implementation of the Care Act.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

(Setting aside the funding reform elements proposed for April 2016)

The Care Act will be implemented in stages between 2014 and 2016.

Amongst the key changes are

- national eligibility criteria;
- new responsibilities for information and advice;
- increased rights and access to services for carers;
- Adult Social Care funding reforms.

It is likely that these changes will have a significant impact on publicly funded Adult Social Care, and therefore, increase the financial pressure on the Council.

At this stage it is too early to make a full assessment about the scale of this impact.

Since the draft BCF was submitted, Local Authorities have received confirmation of their specific allocation from a national investment of £135m for the implementation of the Care Bill. This forms one of the elements of the overall BCF financial envelope for each Authority and its partners. The Leicester City allocation is circa £0.84m.

There will be further allocations of resources directly to Local Authorities in 2015/16 to pay for implementation of the non-financial reform elements of the Bill and in 2016/17 to fund the financial reforms. There is a risk that these allocations will not fully fund the actual costs.

The Council has a comprehensive Care Act Implementation Programme, covering all aspects of change required from April 2015. This will ensure that the Council is able to meet its new duties. Financial and demand modelling are still an issue of national debate, and at this stage it is unclear whether the funding allocations within BCF will be sufficient to accommodate the new legislative burdens relating to assessment, eligibility and carers specifically, as well as prisoners. This will continue to be monitored as plans are implemented.

The Care Act implementation plan is in part allocated to the Council's BCF implementation team for delivery, where the changes required have inter-dependencies with BCF integration schemes; this is specifically designed to avoid disconnect between these two major change programmes.

v) Please specify the level of resource that will be dedicated to carer-specific support

£650k of BCF resources are dedicated to carer specific support. In addition there is £429k (as part of the £840k Care Act monies assumed within the allocation to the Local Authority) for the implementation of Care Act provisions relating to carers assessments and services.

Local financial modelling however has estimated the costs of new duties re carers to be much higher that this (c £800k - £1,000k).

Carers direct support will be delivered by carers personal budgets, enabling carers to have control over the resources they require to maintain their caring role, In addition, a range of preventative services will be available, such as Caring with Confidence training, advocacy and advice. There will also be access to services that are provided to cared-for people, to provide respite to their carer, including a flexible short breaks service offer.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

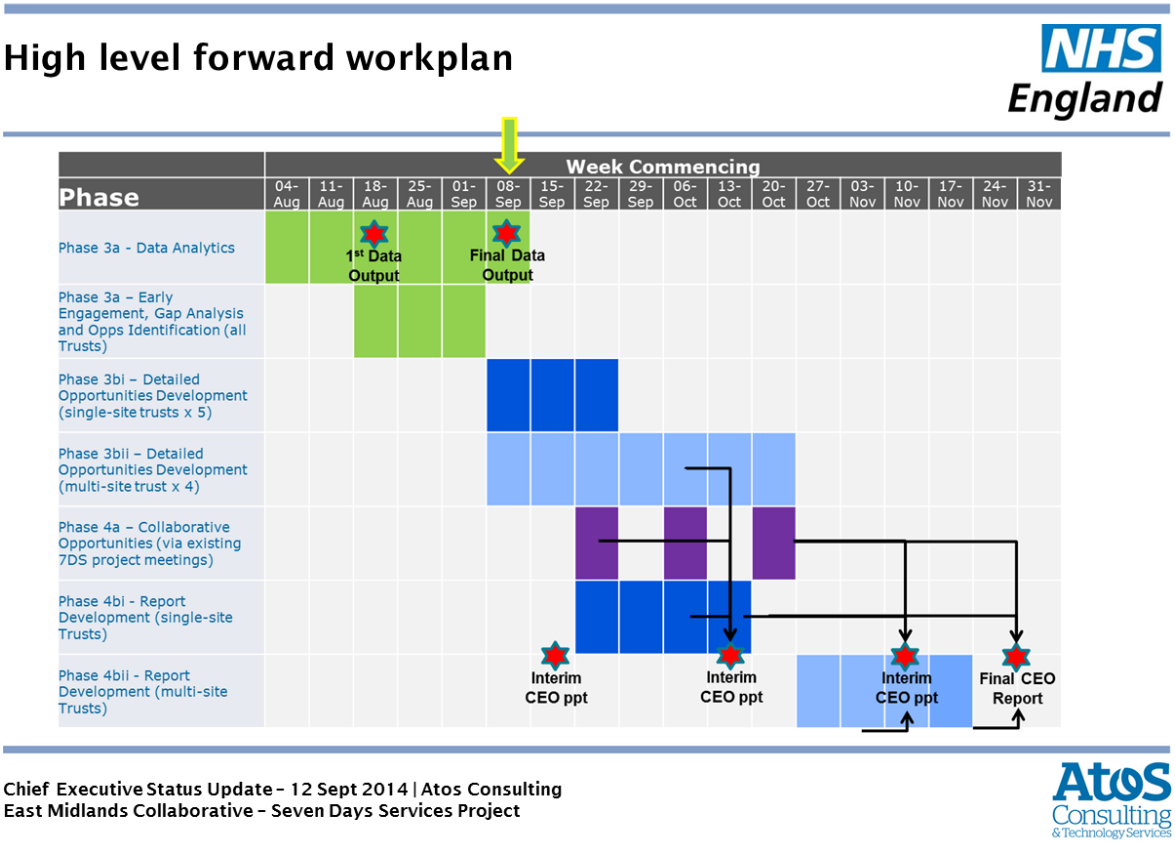
There has been no change to the council's budgetary position against the original BCF plan.

a) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Following the publication of NHS England's clinical standards for seven day working, all Acute Trusts in the East Midlands are undertaking a baseline assessment against the ten elements of the clinical standards and a regional workshop has been held to share emerging practice and models of care to support this work. The baseline assessment will include an overview of how other elements of the health and care system that intersect with acute providers on a seven day basis are being configured to support seven day working, for example the Unscheduled Care team which offers a combined health and social care response to avoid admissions where urgent help is needed in the community.

Key milestones associated with this are represented below:



Locally, across the city, there are already specific community health and social care services available over the weekend but we recognise that traditionally these have been poorly utilised, both for admissions avoidance and discharge. Test weekends (run earlier this year) have proven that a more integrated model of seven-day working across front-line health and social care is vital for a more responsive and patient-centred service.

As part of our commitment to deliver seven-day services, the 2014/15 Acute Service Development and Improvement Plan includes a specific action plan to deliver against the clinical standards outlined in the 7DS document. This is monitored and delivered through

the Leicester, Leicestershire and Rutland Urgent Care Working Group but due to the interdependencies, is also aligned with the BCF plans for 14/15. We will evaluate the impact of these and where relevant will move these into the quality requirement section of the NHS Standard Contract for 15/16 and 16/17.

Our Better Care Fund plans include seven-day working (where applicable & feasible) as a standard expectation to support the flow across the health and social care system. For example, most schemes mobilised in 2014/15 through the Better Care Fund have been on a seven-day service expectation. This includes the Clinical Response Team, the Unscheduled Care team and the Planned Care Team in the first instance; however, we expect some services to expand to seven-day working in Q1 2015/6 where workforce allows across health and social care.

Alongside this, the CCG has invested an additional £1.6m in primary care in the city in 2014/15 to support the BCF plans; plans have been proposed by GP localities and been formally approved by the CCG Governing Body. These plans collectively include systematic access to primary care and support to discharge of patients across 7 days where appropriate and evidence-based.

How will the BCF interventions enable 7 days services to be delivered?

BCF Intervention	**Impact on 7 day service provision**
General Practice scheme (2.1-10%)	Enhanced access to primary care
Clinical Response Team	7 day service to prevent hospital admissions
Unscheduled Care Team	7 day service to prevent hospital admissions
System Integration Coordinator	7 day service to prevent hospital admissions and increase weekend discharge
Intensive Community Support service	7 day service to prevent hospital admissions and increase weekend discharge
Planned Care Team	7 day service to prevent hospital admissions and increase weekend discharge
Mental Health Discharge Team	7 day service to prevent hospital admissions and increase weekend discharge

b) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

What we have done so far

Leicester City Council and partners are committed to using the NHS number as the primary identifier. Leicester City Council has procured a new social care system called Liquid Logic. Liquid Logic has very recently, April 2014, been deployed and implemented for Children's and Adult Social Care.

Liquid Logic does allow for the NHS number to be imported and used as a primary identifier along with capabilities for real time validation to support day to day operation working.

What we plan to do next

To ensure that Liquid Logic can use the NHS number as a primary identifier, Leicester City Council have started engagement with HSCIC to ensure appropriate procedures are in place to have access to the NHS number. The Council is in the process of applying, as a commissioner; to the HSCIC for the NHS numbers in order to bulk populate Liquid Logic records with verified NHS numbers. This phase is anticipated to be complete around November 2014.

Leicester City Council have also developed plans and are currently working towards developing a technical infrastructure between Liquid Logic and the NHS SPINE in order to make available Personal Demographic Data to social care front line staff. This second phase is anticipated to be complete around January 2015.

Role based access control will be in place as part of deployment and relevant staff will be trained to use the NHS number. The NHS number being used as the primary identifier is anticipated to become standard procedure by January 2015.
All future information sharing agreements between the Council and health partners will include the NHS number as a specific piece of data that is required.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Leicester City Council is firmly committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK)). Any new systems that are procured for health and social care will have this as a core requirement. This will allow greater interoperability between systems and allow for greater electronic sharing of information.

The first step in the process has been to procure a new social care system (Liquid Logic). Liquid Logic has the ability to communicate and interoperate with health's IT systems. Once installed, the Council will work with health partners to ensure that information flows

between health and social care are carried out electronically, securely and safely by using national standards.

The Council is currently a member of the NHS LLR IM&T Strategy Board. A key objective of this Board is to look at opportunities of sharing and using information better between various organisational systems to improve patient care. Open APIs, Open Standards and ITKs are reviewed as part of any new solution that the Board take forward.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Leicester City Council, Leicestershire Partnership NHS Trust and Leicester's Hospitals are signed up to the Leicestershire information sharing protocol which sets out the minimum standards expected from secure transfer of personal data (e.g. secure email, encryption, pass worded documents, registered post, secure FTP transfer). Newly formed health organisations such as the CCG and Greater East Midlands Commissioning Support Unit (GEM) are currently being invited to sign up.

Where data sharing takes place between these organisations written information sharing agreements are put in place. The county-wide Leicestershire Strategic Information Management Group are currently producing security standards for all partners in the county to adhere to when sharing information based on these standards.

We can confirm that we are committed to ensuring that the appropriate IG Controls will be in place. The existing county-wide information sharing protocol already introduced robust information governance standards across the county and followed Caldicott principles where health data was involved.

An information sharing protocol has been drafted between partners to cover all aspects of information sharing as part of the Better Care Fund. Individual information sharing agreements will be implemented for data sharing relating to the Better Care Fund.

All partners are committed to reviewing their relevant IG policies and fair processing notices to reflect the Caldicott 2 recommendations, and future information sharing agreements will reflect this. Leicester City Council has obtained level 2 of the NHS IG Toolkit for both Public Health and Social Care.

Leicester City Council last year introduced mandatory online data protection training for all staff and with the support of management in social care, annual refreshers will be implemented in 2014.

The Council has a named Caldicott Guardian within the organisation. The Guardian plays a key role in ensuring that the Council with social services responsibilities and partner organisations satisfy the highest practical standards for handling patient identifiable information. The Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information.

How will the BCF interventions enable the NHS to be the primary identifier?

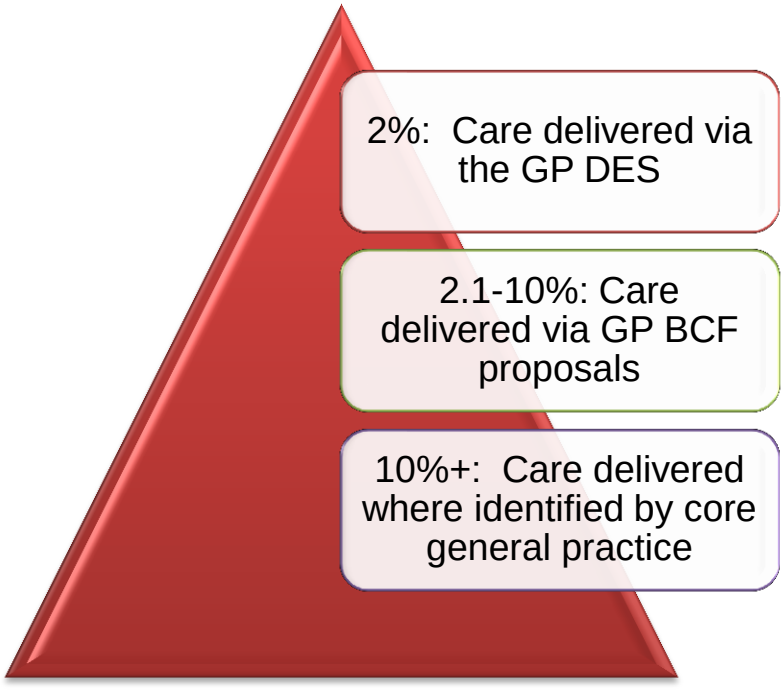
BCF Intervention	Impact on IT services
IT integration	Will enable the use of the NHS number as a primary identifier

c) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Proportion of high risk patients

As outlined in the case for change above, using the Adjusted Clinical Groups (ACG) risk predictive software, this is approximately 7,200 people or 2% of the 370,000 residents of the city. We are working with our practices to implement proactive, holistic and responsive services for those patients identified using our RS model, using the following model of care:



The new DES that came into effect in 2014/15 and is focused upon providing targeted support for the top 2% of at risk patients.

Using our local population definition of those aged 60+ or 18-59 with three of more comorbidities, a further modelling exercise took place in July 2014. This resulted in a

targeted cohort of patients (next 2.1-10% at risk) identified as high risk of admission with specific services available to support these patients.

In partnership with our general practices, our 'Planned Intervention Team' will be key to managing both the health related aspects of care required by these patient but also the social care required to manage the patient care in the community and to keep the patient independent. A care navigation team are also in place to support the clinical lead in identifying the most appropriate service elements for their patient.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Leicester City CCG has a running programme for the provision of high quality, personalised care planning, based upon a SystMone template.

As described above, we have worked with general practice to apply the risk stratification system to their population and provide multi-disciplinary assessment and care for those patients identified as being at highest risk, specifically focussing upon the top 10% of high risk patients in the first instance.

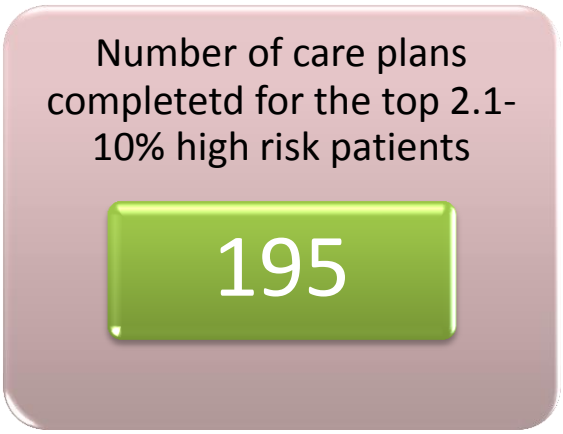
As part of our CCG Operating Plan 2014-2016, we have a commitment to ensuring that all patients over 75 registered in Leicester City have a named GP and those at high risk within this cohort will have a joint health and social care plan to enable proactive care management, integrated around the patient. This is described in detail below.

We will also apply the same methodology to our target cohort of patients (over 60 years and 18-59 with 3 or more comorbidities); this will involve prioritising our high risk patients from this cohort and provision of a personalised care plan where required. This is a longer term strategic commitment, delivered on a phased basis and driven by the risk predictive scores of the population.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Each practice has an agreed risk stratified BCF cohort on which to focus on, with an agreed template to coproduce with their patient/Multi-disciplinary Team.

As at August 31st 2014:



Patients in the 2% cohort will benefit from the interventions detailed in the '*Avoiding unplanned admissions Enhanced service: proactive case finding and care review for Vulnerable people'* document (April 2014).

All 62 practices in the city have signed up to delivery of this DES which requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access. In addition, the practice is also required to provide timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or ED attendances and to have a named GP accountable for their care.

In addition to this, an additional £1.6m has been invested into primary care in the city, to deliver targeted services to a further cohort of vulnerable patients. Patients in the 2.1-10% highest risk cohort are not only provided with care plans but a whole suite of interventions, to include:

- Undertake routine assessments of patients with long term conditions in their home. This helps people with such conditions to better manage their own health and avoid unnecessary visits to hospital.
- Increase population-based interventions e.g. access to vaccinations, reducing social isolation, increasing access to third-sector and Local Authority services.
- Improve, for selected high-risk individuals, chronic disease management, medicines related safety and concordance.
- Improve self-care and self-management skills; reiterating Choose Better campaign messages where appropriate.
- Promote use of personal health budgets.
- Provide both proactive and reactive care
- Assess carers health needs; enhancing the resilience of the carer population.

- Prescribe and administer medications within the remit of local PGD, where appropriate, and undertake medication reviews across the cohort.

- Take a holistic approach to patient care, bringing together their medical, social and psychological needs – both for patients and carers.

- Refer patients to alternative health and/or social services through appropriate signposting and guidelines, linking with the wider BCF services and supporting patients in their own homes.

- Ensure high quality, detailed care plans are in place and up to date/reviewed.

SMART objectives have been agreed by at practice and locality levels to ensure delivery of targets and these form part of the Leicester City Integrated Care Dashboard as referenced in Section 7.

d) How will the BCF interventions enable a joint assessment and an accountable lead professional for high risk populations?

BCF Intervention	Impact on joint assessment and accountable lead professional for high risk populations
Risk stratification	Will enable the 0.1-2% and 2.1-10% cohorts to be identified
General practice scheme (2.1-10%)	Will deliver targeted care planning function to high risk populations
Unscheduled Care Team	Will enable joint assessments of populations, with accountable care professionals coordinating care for high risk patients
Planned Care Team	Will enable joint assessments of populations, with accountable care professionals coordinating care for high risk patients

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

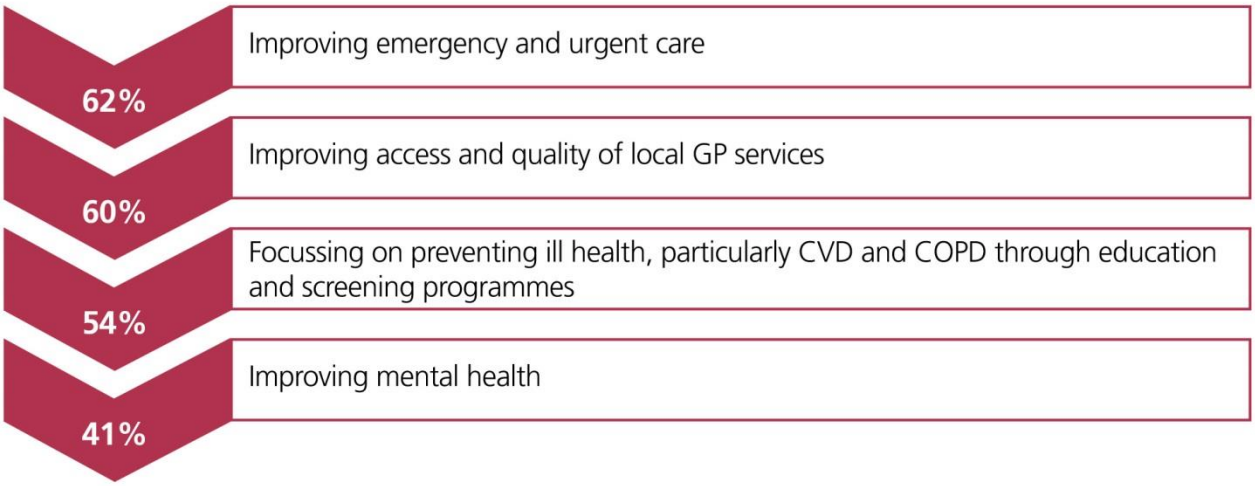
In developing priorities for the city, public views on the priorities for the city were sought at the start of our integrated care journey in 2013/14. This was done via a number of methods, including a survey (standard and easy read formats), visits to local organisations, community groups and service users and via a public workshop.

These methods were selected to offer stakeholders a wide range of ways to get involved, and to ensure we had both quantitative and qualitative feedback.

Public views on the city priorities were sought via a broad survey sent to all city stakeholders including partners, organisations, community groups, patients, carers and members of the public.

The survey asked what the main healthcare priorities for the city should be, by offering a number of options as a prompt. Respondents also had the opportunity to offer their own suggestions. A number of additional questions broadly asked for comments on the local NHS for input into future consultations.

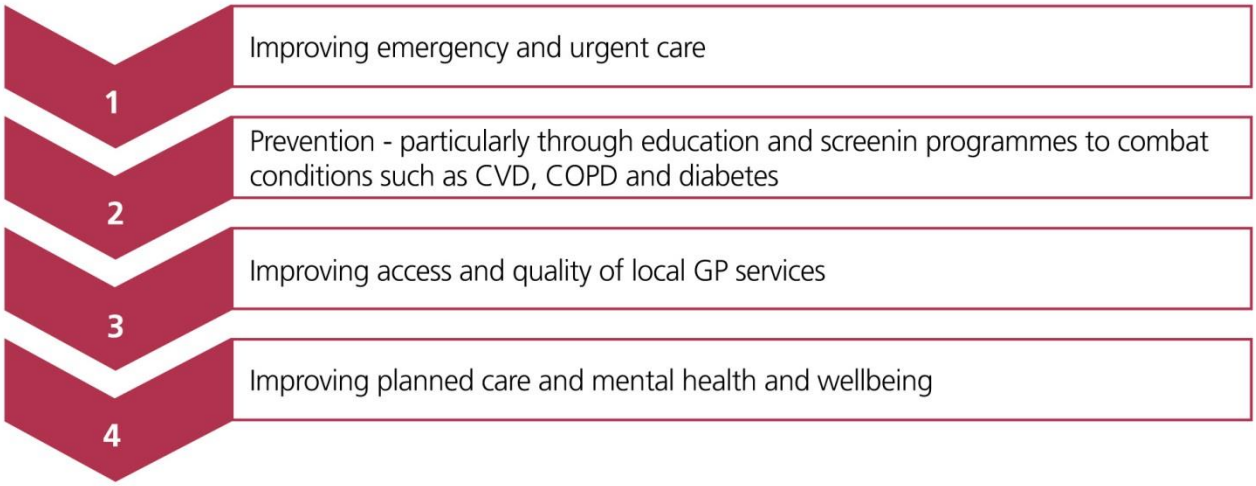
From the survey, four clear priority areas were identified by the public and stakeholders. These were:



Briefings were arranged with key community groups and organisations to ensure the engagement on healthcare priorities was widely sought and to encourage key stakeholders and hard to reach group to give their views. A number of these briefings included meetings with service users as well as directors and executives. These organisations covered each of the equality strands.

In addition, stakeholders across the city were invited to attend a public workshop. Those invited included statutory organisations, NHS Leicester City public members, voluntary sector and community groups, and members of the public. All local MPs and the city council's Overview and Scrutiny Committee were briefed and invited to attend. In total 50 stakeholders participated in the workshop.

From the discussions that took place at the individual briefings and public workshop key priority areas were identified and ranked. These were:



Given the alignment of these priorities to the evidence base presented earlier in this plan, the outputs from this engagement have been used as a basis for development for the interventions in our Better Care Fund:

Priority area identified	BCF intervention
Improving urgent and emergency care	Clinical Response Team
	Unscheduled Care Team
	System Integration Coordinator
	Intensive Community Support service
	IT integration
Prevention (CVD, COPD, diabetes)	Lifestyle Hub
Improving access and quality of local GP services	Risk stratification
	General Practice scheme (2.1-10%)
	Planned Care Team
Improving planned care and mental health and wellbeing	Mental health discharge team
	Integrated Mental health step down service

Further engagement has taken place since 2013 and into 2014 around our aims for systemic transformation, and we first introduced the concept of the Better Care Fund at our joint Call to Action event on 3 December 2013.

The event, which was aimed at stakeholders, patients, carers and members of the public from across the city, presented an outline of the Better Care Fund, its national goals and objectives and tasked attendees with identifying and sharing areas for improvement in health and social care.

The key themes that emerged from the engagement are the importance of carrying out a full assessment of all of a patient's needs, including health, social care and mental health; integrating care into community settings and putting the wishes of the patient at the centre of decision making; all of which have directly influenced the initiatives in this plan.

To commence moving our plan into implementation, a further workshop event took place in March 2014, seeking to validate the priorities identified and explore how we should measure and pay for 'good' and 'excellent' health and social care through our emerging model of Outcomes-Based Commissioning rather than traditional contracting methods. This was a 3 hour session attended by 30 local people. The outputs have informed the CCG's potential move towards outcomes based commissioning as a model of contracting in the future.

In October/November 2014, further engagement is planned with patients and service users to outline progress to date on the BCF and to gain an understanding of views for the next phase of our programme.

Alignment to engagement in other programmes of work

The Leicester, Leicestershire and Rutland Patient and Public Involvement Group, which is currently chaired by a member of Leicester City Healthwatch, has been set up to provide citizens' scrutiny of the five-year strategy that is being developed across LLR. Throughout February and March 2014, a series of workshops were held for the LLR five year strategy and this opportunity was used to further engage on the Leicester City BCF priorities and plan.

Significant engagement will be carried out to support the implementation of the five year strategy, which will also be relevant to the Better Care Fund. Representatives of Leicester City patients will continue to be part of this group and will ensure that the wider population have the opportunity to have their say.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

There is a strong, substantial and successful history of collaborative working across health and social care in Leicester, enabled by robust clinical and political support. This culture of meaningful and effective collaboration has already enabled partners in Leicester to make a real difference, notably through the development of a number of schemes and initiatives aimed at reducing health inequalities in the city.

The leaders of the Leicester, Leicestershire and Rutland health and social care economy have developed an overarching vision setting out the changes needed in the local health and social care system over the next five years. This work involves all partners including providers and culminated in the LLR Better Care Together Five Year Strategy in June 2014.

We have worked closely as one health and social care community on both Two and Five Year plans, aiming for systemic change that provides the right level of care at every step of the patient pathway. Full and open engagement with partner organisations has greatly informed the specific schemes detailed in this paper.

i) NHS Foundation Trusts and NHS Trusts
ii) Primary care providers
iii) Social care and providers from the voluntary and community sector

Organisations we have included in the development of our plan include general practitioners across Leicester City, Leicester City Council, Leicestershire Partnership NHS Trust (LPT), East Midlands Ambulance Services NHS Trust (EMAS), University Hospitals of Leicester NHS Trust (Leicester's Hospitals), Central Nottingham Community Services (CNCS) our GP Out Of Hours provider and Voluntary Action Leicester (on behalf of the VCS).

Our 2 biggest providers of health services, UHL and LPT, have been involved in shaping this programme from the outset and are represented throughout the Governance arrangements for this programme of work, from the strategic oversight of the plan, through to BCF Implementation group and specific task and finish groups. Sustained engagement will continue as we implement these plans.

On September 9th 2014, the final plan was presented to the UHL Executive Team, with agreement regarding the direction of travel of the plan and explicit agreement to continue the successful collaborative working across the system. Equally, on September 15th 2014, the final plan was presented to the Heads of Service at LPT, again, with ongoing support confirmed.

Our Plan has also been presented to 'Protected Learning Time' events for general practitioners and their staff, both clinical and managerial every month since the introduction of the BCF. Individual engagement has taken place at each of Leicester City's four general practice localities to further understand the impact of the BCF on

primary care and to develop supporting plans for additional funding made available to general practice to support the implementation of the BCF.

Local Authority representatives, including elected members and teams from adult social care services have been integral to the development of this plan and Healthwatch have been a vital partner in our planning so far. Both the Adult Social Care and Health Scrutiny Commissions have also had input into the plan, with briefings held on March 6th 2014 and April 1st 2014 respectively.

The voluntary sector across Leicester City has also been engaged, with workshop sessions held specifically with local agencies to identify how this sector could strengthen our plans, with workshops held on March 11th 2014 and again on June 10th 2014.

Implications of BCF delivery have been reflected in the operational plans of all partner organisations (specifically UHL and LPT) and will be managed and monitored through the BCF Implementation Group where required.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The long-term strategic direction of travel for the Leicester, Leicestershire and Rutland health and social care economy has been agreed collectively at the five year strategy Programme Board. The membership of this includes Chief Executives and Lead Clinicians of all agencies across Leicester, Leicestershire and Rutland to ensure that individual organisations' plans, geographically aligned change programmes and all other plans strategically fit together.

The Leicester City Better Care Fund programme will regularly report into this programme to ensure that any modelling, in terms of activity reductions or increases, is explicitly understood by all organisations at an executive level as well via individual work streams at ground level.

There is an already established understanding that to achieve the shift of activity from an acute setting into the community will need significant investment in pre-hospital services, in both primary and community care. The Leicester, Leicestershire and Rutland *Better Care Together* five year strategic plan, due to be completed in draft form by June 2014, will set out our vision for this.

This may include:

- increasing the community footprint for Leicester, Leicestershire and Rutland;
- improved provision and access to primary care services, including an upskilling of GPs in Leicester City to provide more complex care in the community;
- downsizing the acute footprint for Leicester, Leicestershire and Rutland.

Leicester's Hospitals are currently consulting with their clinical base to assess options for a strategic outline case, looking at options available for the UHL footprint. Leicester, Leicestershire and Rutland CCGs have been an active part of this process and continue to support UHL in this objective.

The schemes detailed in this paper will support any downsizing by significantly reducing activity flowing into Leicester's Hospitals and increasing faster activity flows out. The schemes also enable the requirement set out in the NHS Planning Guidance 2014/15-2018/19 to reduce emergency hospital activity by 15%.

Clinical engagement from Leicester's Hospitals, Leicestershire Partnership Trust and East Midlands Ambulance Service for these schemes has been ongoing through the life of the Better Care Fund and will continue throughout to ensure that the ambitions set out in this paper are owned by the health and social care economy as a whole.

UHL clinical and strategic leads have been part of the BCF design process since Nov 2013, with senior clinicians (Dr's Simon Conroy and Richard Wong and Kate Shields, Director of Strategy) engaged at design stage. Representatives from UHL sit on the bi-weekly BCF Implementation Group (Head of Strategic Change, UHL) and senior UHL clinicians sit on each of the key sub-groups. The model of care has been presented to, and supported by, the UHL Executive Team (Sept 9th 2014) and has been supported by the UHL Clinical Director for Emergency Medicine.

At the time of this submission, an additional re-admission avoidance scheme is in the process of being developed with University Hospitals of Leicester which will be targeted to cardio/respiratory patients.

What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?

Significant activity shifts are expected as a result of the BCF. These have been mapped at an LLR level in order to quantify the total impact on the activity and income assumptions made at Provider level through the LLR five year strategic plan.

The schemes propose a 3.5% reduction in emergency admissions, resulting in 1013 reduction in emergency admissions. 2014/15 activity and subsequent financial impact has already been contracted with UHL. 2015/16 will be subject to annual contract negotiation but a trajectory for reductions in emergency admissions will continue in line with the LLR five year Plan.

These assumptions take into account CCG QIPP schemes and therefore there is no duplication in BCF assumptions.

Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Since the beginning of 2013/14 UHL have been operating at a financial deficit, which is expected to reach £39.8m by the end of the financial year. UHL has struggled with an unsustainable underlying financial deficit for a number of years, which has been compounded by an escalation in its spending during 2013/14 and some assumptions made by the Trust about income from CCGs and elsewhere which had not been agreed.

Much of UHL's deficit has however been driven by an inability to recruit medical and nursing staff ensuring that this level of support is now at c. £4m per month. Accordingly a reduction in emergency activity at least initially should be mutually beneficial with reductions in income at UHL more than offset by reductions in agency and locum costs and therefore contributes positively to the underlying UHL deficit.

There will inevitably be a point at which further removal of acute work will require UHL to start to reduce resources including physical and human. The scope and pace of this will require further detailed analysis and it is our expectation that there will potentially be a need for transitional support from the 1% transformation fund for UHL during this period.

There has been an increase in interventions aimed at mental health service users and therefore no negative impact on the level and quality of mental health services will be seen.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.